|  |  |  |
| --- | --- | --- |
| C:\Users\Mark\AppData\Local\Microsoft\Windows\INetCache\Content.Word\CDAC_1_150x150.png | **Coastal Districts Athletic & Community Club****Season 2017/2018 Membership form** |  |

**Please complete all pages**

**Personal Details (click to the right of the item to enter details)**

Surname: Surname

Given Names: Given names

Date of Birth: DOB.

Gender: M [ ]  F [ ]

Phone (H): Home phone number

Phone (M): Mobile phone number

Email Address: Email address

Postal Address:

Street details: Street number and street

Suburb: Suburb

State: State

Postcode: Postcode

**Fees**

Annual fees comprise of a Membership fee and Coaching fee payable via Athletics SA (ASA) (<http://www.athleticssa.com.au/>). There are three fee structures to choose from

1. Fees for those competing, eg Beach, SAAL, ASA:

|  |  |
| --- | --- |
| **Fee** | **Total** |
| Annual Membership fee  | $50 |
| Annual Competition Coaching fee | $200 |
| **Total Coastal Fees**  | **$250** |

1. Fees for non-competitors utilising coaching for recreation or fitness eg in between primary sport, footy, netball

|  |  |
| --- | --- |
| **Fee** | **Total** |
| Annual Membership fee  | $50 |
| Annual Recreational / Fitness Coaching fee | $100 |
| **Total Coastal Fees**  | **$150** |

1. Fees for non-coached members

|  |  |
| --- | --- |
| **Fee** | **Total** |
| Annual Membership fee  | $50 |

**Consent**

I agree that photos taken may be used in electronic and print media by Coastal Districts Athletic & Community Club and any affiliated sporting organisations.

I authorise the CDACC personnel to obtain medical assistance which they deem necessary should an accident occur and agree to pay all medical and dental expenses incurred.

I further legally authorise qualified medical practitioners to administer an aesthetic or carry out necessary surgical procedures if such an eventuality arises.

I submit the attached health information and include details of limitations for the activity concerned.

I agree that if I win a prize in excess of $100 I will donate 30% to the CDACC coaching group.

The information given in the attached sheets is accurate to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

(Signature of Athlete)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

(Signature of Parent/Guardian if Member Under 16)

**Details of Parent/Guardian if Member Under 16**

**Mother/Guardian**

Name: Surname

Phone (H): Home phone number

Phone (M): Mobile phone number

Email Address: Email address

Postal address where different to member:

Street details: Street number and street

Suburb: Suburb

State: State

Postcode: Postcode

**Father/Guardian**

Name: Surname

Phone (H): Home phone number

Phone (M): Mobile phone number

Email Address: Email address

Postal address where different to member:

Street details: Street number and street

Suburb: Suburb

State: State

Postcode: Postcode

**Alternative Emergency Contact**

Name: Surname

Phone (H): Home phone number

Phone (M): Mobile phone number

Relationship to member: Relationship

**Medical Conditions**

Do you have any know medical condition, health problem, allergy or disability? Yes [ ]  No [ ]

If “YES”, please give details:

Details

Are you aware of any medical emergency which could occur? Yes [ ]  No [ ]

If “YES”, please give details:

Details

Precautions to avoid emergency:

Details

How to recognise emergency:

Details

Emergency treatment required (Please attach copy of emergency plan if held):

Details

**Medication**

Do you take any prescribed medication (including inhalers)? Yes [ ]  No [ ]

If “Yes”, please give details:

Medication Name: Name

Dose: Dose

When to take: When

How to take: How

**Limitations**

Are there any limitations on any activities? Yes [ ]  No [ ]

If “YES”, please give details:

Details

**Medicare / Health Fund**

Medicare number: Number

If you are a member of any private medical benefit fund, please provide details:

Membership No: Number

Fund Name: Name

Benefit Tables: Details

Ambulance subscription number if applicable: Number