REGISTRATION FORM – MOTHER/CAREGIVER

Event Date_____

These details will be kept confidential by TIDES.

Name(s): _____Surname: _____

Address: _____

_____

Phone Home: _____Mobile: _____

Email: _____

MEDICAL DETAILS

Date of birth: _____

1. Do you have any medical condition that may affect you while at Tides?
If yes please give details e.g. if you suffer from asthma list triggers of attacks, strategies for easement and list clearly what medication you may be taking.

(If taking medication please ensure you have what is needed throughout the event).

2. **Dietary requirements?** (E.g. gluten free, vegetarian)

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Emergency Contact Details:
In case of accident or illness please advise whom you wish to be notified:

First name(s): _____Surname: _____

Relationship to participant: _____

Address: _____

Phone Home: _____Work: _____

Mobile: _____Email: _____

TIDES CONSENT FORM – Mothers/Caregiver

• I understand that it is important for my safety and for the safety of others that any instructions given by a member of Tides staff are obeyed at all times.

• I understand that activities may involve walking for several hours, running, jumping, water and use of adventure equipment thus exposing myself to situations and physical activity not encountered at work or home.

• I acknowledge that while TIDES and its staff will make every reasonable effort to minimize exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of TIDES and its staff.

• I understand that my involvement in the TIDES Program may mean I am remote from immediate medical help. I have provided TIDES with enough written information to deal appropriately with any medical conditions I may have.

• I further authorize TIDES, in the event of any injury or illness, and where it is not possible or reasonable to obtain my consent at the time, to engage a medical
practitioner, ambulance or hospital facilities. In this event I agree to pay all such emergency evacuation, ambulance, doctor, nurse and/or hospital expenses.

• I have read the Registration/Medical and Consent Forms and understand the level of involvement required of me.

Name: _____

Signature: _____

Date:_____

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