



## Membership Application Form 2009

EXISTING MEMBER	<input type="checkbox"/>	NEW MEMBER	<input type="checkbox"/>
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### Young Person's Details

All personal details are kept strictly confidential and will not be shared with any third party

Surname:		Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
First Name(s):			
Home Address:			
		Postcode:	
Telephone Number (Home):		Date of Birth:	
Mobile Number:		Please send YBC information to me by email (Tick If Yes): <input type="checkbox"/>	
Email Address:			
School, TAFE, University Name/Workplace:			
Young person's signature:			

### Youth Building Community Terms & Conditions

Please read through the following and tick the boxes. Detailed information on membership is available on our website.

Membership is FREE, but in exchange I agree to share the vision of the YBC	<input type="checkbox"/>
I agree to abide by YBC's Code of Conduct and Direction given by YBC Leaders	<input type="checkbox"/>
I agree to have photographs of me taken by YBC used for publicity and promotional purposes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Young person's signature:	Date:
Parental signature (if under 18 years):	

### Help Us Make YBC Great

Support the YBC by letting us know if you or someone you know can help us provide our range of youths services

Licensed to drive a minibus <input type="checkbox"/>	Be a youth worker <input type="checkbox"/>	Make a donation <input type="checkbox"/>
Other <input type="checkbox"/>	If other, please state:	

### Official Use Only

Do not complete this section of the form

Membership Number:	Added to Mail List: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	Added By:
Date Entered in Database:	Added By:	



## Medical Details

By signing this medical release I/We the Parent(s)/Guardian(s) of the child named below, do authorize the YBC to seek and obtain treatment of my/our child by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the YBC representative or attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me/us.

This release is effective for the year 2009. This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment for my/our child in my / our absence. I am responsible for any medical and transport expenses as a result of any such treatment.

Child Name: \_\_\_\_\_ Male:  Female:

Home Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please state any medical conditions, allergies or disabilities of which we need to be aware to provide appropriate support:

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Dated: \_\_\_\_\_

## Parent/Guardian Emergency Contact Details

In case of emergency, we request direct contact details.

Parent/Guardian Name: \_\_\_\_\_ Contact Number (Home): \_\_\_\_\_

Contact Number (Mobile): \_\_\_\_\_ Contact Number (Work): \_\_\_\_\_

Home Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Name of Second Contact: \_\_\_\_\_ Contact Number (Home): \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Number (Mobile): \_\_\_\_\_