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Blind Foundation logo including strapline of Beyond vision loss

## Blind Foundation Whanganui River Journey

Document No: REC019 - Revision 1.0

Name of Event: Whanganui River Journey

Location: Whanganui

Start date and time: Thursday Morning 12 October 2017

Finish date and time: Sunday Evening 15 October 2017

**Please note there are 2 sections to this form. Please ensure both are completed, and return the form to the coordinator of this programme**

## Section 1: Participant details

**Name**:

**Address**:

**Telephone**:

**Mobile**:

**Email address**:

**Age/Date of Birth**:

Emergency Contact Details (during the time of the journey)

**Name**:

**Relationship**:

**Address**:

**Email**:

**Day phone**:

**Evening Phone**:

**Mobile**:

Eye Condition:

**Partially sighted**: Yes / No

**Totally Blind**: Yes / No

**Corrected visual acuity** (if known):

**Do you wear glasses?** Yes / No

**Contact lenses:** Yes / No

**Do you use a cane?** Yes / No

**Do you use a guide dog?**  Yes / No

**In what format do you prefer to receive information? e.g. email, braille, text, CD, large print etc**:

**How well are you able to use the vision you have in everyday situations? e.g. getting around, steps, poor light conditions**:

# Background information

**Please tell us in 150 words or less why we should select you to come on the journey?**

**What do you hope to gain for attending this journey?**

**Have you been on a Whanganui River Journey before?**

## Section 2: Health profile and medical consent

(This section is designed to assist with the care of all participants on Blind Foundation programmes)

**Family Doctor**:

**Telephone**:

**Medic Alert Number** (if applicable):

**Community Services Card number**:

**Expiry date**:

# Medical/Health Conditions

**If you are unsure whether any current medical condition may affect you during this event please consult your doctor to ensure your wellbeing before commencement.**

Please indicate yes or no if you suffer from any of the following, and the treatment / first aid that may be required:

**Migraine**: Yes / No

**Asthma**: Yes / No

**Diabetes**: Yes / No

**Travel sickness**: Yes / No

**Seizures of any type**: Yes / No

**Heart condition**: Yes / No

**Dizzy spells**: Yes / No

**Colour blindness**: Yes / No

**Hearing impairment**: Yes / No

**Other**: please give details of other medical conditions/disabilities

**Do you have any allergies**? Yes / No If yes please state along with treatment:

**Are you currently taking medication?** Yes / No If yes, please state name/s of health condition/s and medications/s:

**Please outline any special dietary requirements**:

**Do you need support with personal care?** Yes / No If yes please specify:

**Please provide any other information that we should be aware of regarding your health and safety**:

# Declaration:

I, the undersigned, have disclosed all necessary information to ensure my safety and well-being during this event.

I understand that places are limited. Also that due to the nature of some activities and / or external provider requirements, additional specific selection criteria may be used. This may mean I may not be selected for participation on this occasion.

I will inform the Blind Foundation event coordinator as soon as possible of any changes in my medical and /or other circumstances that may arise between now and the commencement of the programme

I understand that any injuries or illness will in the first instance be attended by a Blind Foundation staff member trained in first aid. I agree to receiving any emergency medical, dental, or surgical treatment as may be considered necessary by the medical authorities and that this will be secured at my expense.

I consent to be involved in any publicity, including photographs.

The staff and volunteers will exercise all due care, but will be clear of all liability in the event of any injury, damage or loss I may sustain to person or property.

I have read the event information sheet and I understand that there may be risks associated with involvement in Blind Foundation events and that these risks cannot be completely eliminated. I understand that the Blind Foundation will identify any foreseeable risks or hazards and implement correct management procedures to eliminate, isolate or minimize those hazards.

**Signed by**:

**Date**: