**WAHINE ENROLMENT FORM**

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| Name: Age:  |
|  |
| Home Address: |
|  |
| Phone: | Post Code: |
|  |  |
| Email: |  |

|  |
| --- |
|  |
| Emergency Contact: |
|  |
| Doctor: |
|  |
| **PHOTOGRAPH CONSENT** |
| YES / NO (please circle) Photographs can / cannot be used for promotional material and funding feedback report. |
| **SWIMMING** |
| YES / NO (please circle) How confident are you at swimming?  |
| **MEDICAL / ALLERGIES / DIET** |
| To ensure that we can care for your safety, you need to declare information about your health and wellbeing that may affect your involvement in the programme:Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dietary requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injuries or other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| I give permission to authorise emergency medical care if required: YES / NO |
| **Name: Signature:** |

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| **Terms and Conditions** |
| 1. The Wahine Programme is LIMITED to 15 places a day.
2. Enrolments are ONLY open to wahine living within the Whangaroa rohe.
3. Once the enrolment form has been submitted Myra will be in touch to confirm your place on the programme.
4. Participants are expected to attend all four sessions.
5. A minimum of 24-hours’ notice for no attendance is required.
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| **Days of Attendance**  |
| **Thursday 13th Apr** Yes / No **Friday 14th Apr** Yes / No  |
|  |

The information I have provided on this form is true and correct:

Signature: …………………………………………… Date: .……../………./……………

I acknowledge that there is a risk of incurring an injury that may be due to my participation, and I accept full responsibility for any and all outcomes that may eventuate from my participation in this programme. Additionally, I accept full liability for any loss or damage that may result from my participation in this programme and indemnify Whangaroa Health Services for any loss or liability claim directly arising from this participation.

Signature: …………………………………………… Date: .……../………./……………

**Whangaroa Health Services:** (09) 405 0649

**Myra Leaf** (Programme Manager)**:** myra.leaf@whst.org.nz

**EQUIPMENT LIST**

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| **What you need to bring**  |
| To ensure that you are prepared for the programme, you will need to ensure that you bring the following items:* Sunhat
* Suitable Footwear
* Drink Bottle
* Rain Jacket
* Warm Clothes
* Towel & Togs
* Athletic Wear
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