

# Nights Away Information Form



**Event:** PGL **Dates:** 17<sup>th</sup> – 19<sup>th</sup> March 2017  
**Location:** Liddington Near Swindon Wilts  
**Meeting place and time:** 5PM, PGL Adventure Centre Liddington, Foxhill, Swindon, Wiltshire, SN4 0DZ  
**Collection place and time:** 5.30PM, PGL Adventure Centre Liddington, Foxhill, Swindon, Wiltshire, SN4 0DZ  
**Cost:** £85  
**Transport details:** Own Transport  
**Activities:** To be confirmed  
**Further details:** Kit list will be issued nearer the time – sleeping bags & pillows will be required  
**Organiser and contact details:** Keith Holloway, 07884476931, keith.holloway@wiltshirescouts.org.uk  
**Contact details during the event:** Mrs Jane Holloway 01249661185, 07920884623

*Please keep this section for your own information, and detach and return the section below.*

Note: All activities will be run in accordance with The Scout Association's safety Rules. No responsibility for the personal equipment/clothing and effects can be accepted by the organisers and The Scout Association does not provide automatic insurance cover in respect to such items.

Please complete and return this section to Cubs by 4<sup>th</sup> November 2016

**Name of young person:** ..... **D.o.B:** .....

**Event:** PGL March 2017

*I enclose a cheque / cash / pay online (select accordingly) for £25 non refundable deposit (please makes cheques payable to 1<sup>st</sup> Lacock Scout Group)*

*I have noted the arrangements above and agree to the named young person taking part. I understand that the event Leader reserves the right to send any participants home if deemed necessary.*

**Is he/she able to swim 50 metres and stay afloat for five minutes in light clothing? Yes / No**

**Emergency contact:** ..... **Phone:** .....

**Doctor's name and contact details:** ..... **Details of any medications currently being taken:** .....

**Details of any disabilities, conditions, allergies, special needs or cultural needs that might affect this event:** ..... **Details of any infectious diseases he/she has been in contact with in the last three weeks:** .....

*If it becomes necessary for the above named young person to receive medical treatment and I cannot be contacted to authorise this, I hereby give my general consent to any necessary medical treatment and authorise the Leader in charge to sign any document required by the hospital authorities.*

**Signed:** ..... **Date:** .....

**Relationship to young person:** .....

*Please use the back of this form if more space is required*