



ASTRO ACTIVE CENTRE

Multi-Sports Camps Booking Form

Surname:	<input type="text"/>	First Name:	<input type="text"/>
Age:	<input type="text"/>	Address:	<input type="text"/>
DOB:	<input type="text"/>	Parent/Guardian:	<input type="text"/>
Tel Number:	<input type="text"/>	Home:	<input type="text"/>
		Work:	<input type="text"/>

Medical History (Tick where appropriate)

Has your child had: Chicken pox Mumps& Measles

Does your child suffer from any allergies?

Does your child suffer from any of the following:	Yes	No
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>
ADHD:	<input type="checkbox"/>	<input type="checkbox"/>
Autism:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

Disclosure:

I, will drop my child at the camp by 10am and collect my child at end of day (3pm). I have read and understand the attached conditions. I have given, to the best of my knowledge, any relevant information regarding my child(s) medical history.

I enclose: per child Signed: (parent/ guardian) Date:

Camp Ages: 6-9 & 10-13 Years
Times: 10-3 Daily

www.cwcwe.ie



Training &
Developing Ability