

**Private and Confidential.**

Information provided will be recorded in our member database.



Office use only: Date Received: _____ Fee enclosed: € _____ Completed/on system: _____ Signed: _____
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**2018/2019 MEMBERSHIP REGISTRATION FORM**  
**Membership Year July 1<sup>st</sup> 2018 to June 30<sup>th</sup> 2019**

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male  Female

Postal Address  
(For Billing and Class Information) \_\_\_\_\_  
\_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Additional phone numbers \_\_\_\_\_

E-Mail Address  
(For Billing and Class Information) \_\_\_\_\_  
Parent /Guardian Name: \_\_\_\_\_

Home Address:  
(if different from postal) \_\_\_\_\_  
\_\_\_\_\_

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

Parent / Guardian Name Phone Number: \_\_\_\_\_

School / Service Currently Attending \_\_\_\_\_

**Lakers AGM Voter Nomination**

All members over 18 years of age are entitled to vote.  
Any member under 18 years of age or who is unable to vote can nominate a family member, guardian or advocate to vote on their behalf.  
This designated person must be over 18 years of age and present at the A.G.M.

Name of Member: \_\_\_\_\_

Name of Designated Voter: \_\_\_\_\_ Date: \_\_\_\_\_

**Text Messaging**

We often use text messaging to communicate with our members regarding important items such as class cancellation and communication regarding special or activities events (e.g. fun days, fundraising activities, Special Olympics).

**Please indicate which Mobile Numbers to send such messages to:**

Mobile 1: \_\_\_\_\_ Mobile 2: (optional) \_\_\_\_\_

**Data Protection**

Please check the box, beside the relevant statement, **if you wish to OPT-IN**

I Opt-In to have photographs / videos taken of myself or my family member / client for promoting Lakers club activities/programme/events

I Opt-In to have photographs / videos of my family member / client published on the following Lakers Social Media accounts: Facebook  Twitter  Instagram

YouTube  LinkedIn  Google +

I Opt-In to have photographs / videos of my family member / client published on the Lakers website

At times our funding agencies require us to share information with them to compile statistics regarding our membership / attendance of activities / events.

I agree and Opt-In to allow Lakers pass on this information

**I agree that all of the above information is correct and accurate.**

Signed: Member \_\_\_\_\_ Date: \_\_\_\_\_

Signed: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

***Please note: There is an Annual Membership Fee of €20 which should accompany your forms. Do not send cash in the post. Cheques should be made payable to 'Lakers'***

Because this page contains your medical information it is necessary to fill in your name and address again.



**Medical & Consent Form 2018/2019**

***Please ensure all questions are answered***

\_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Member's Medical Diagnosis:

\_\_\_\_\_

Does your family member / client have:

Epilepsy: Yes  No

If yes: In the event of a seizure, is Buccal Midazolam used to stop a prolonged convulsive seizure: Yes  No

**Administration of Emergency Medication: (Buccal Midazolam)**

Criteria and timeline for Administration of Emergency Medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If a seizure occurs do you give consent for trained Lakers staff/volunteers to administer Buccal Midazolam?

YES  NO

### **Sensory requirements**

Does your family member / client have Sensory Processing / Sensory Integration difficulties?

Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please tick the appropriate box and give examples / details  
(over responder / under responder):

Vision

Auditory

Tactile

Proprioception   
(Body awareness)

Vestibular system   
(Movement & balance)

Olfactory (smell)

**Behaviour**

Does your family member / client have any behavioural challenges?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes please give details\_\_\_\_\_

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**Allergies**

Does your family member / client have any Allergies?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes please give details \_\_\_\_\_

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**Diet**

Are there any dietary requirements? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes please give details\_\_\_\_\_

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**Health**

Are there any health issues which may cause you concern?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes please give details\_\_\_\_\_

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**Activities**

Are there any activities you would not wish your family member /client to partake in e.g. Swimming, Climbing?

**Personal Care**

Are there any aspects of personal care that your family member / client may require help with: feeding, toileting, dressing etc.?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes please give details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Relationships**

Please give details of any concerns you may have in terms of relationships?

\_\_\_\_\_

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**Checklist**

Have you answered every question?

Have you included your payment of €20?

Have you answered yes or no to all 4 consent questions?

**Completed forms should be returned to:**

**Lakers  
The Brady Centre, Seapoint Road  
Bray  
Co.Wicklow**

**Please do not send cash in the post.**

**Cheques** should be made payable to ‘**Lakers**’

Electronic payment may be made into Lakers’ bank account, using **the member’s surname & initials as reference to enable us to allocate the payment ( e.g AB Jones):**

**IBAN: IE63AIBK93348108704090**

**BIC: AIBKIE2D**