

**YOUNG COMMISSIONERS**

**MEMBERSHIP FORM**

**Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Young Person**  |  | **Date of Birth:**  |  |
| **Preferred Name:** |  | **Pronouns:** |  |
| **Ethnicity: \*Refer to Key page 2\*** |  | **Gender:** |  |
| **Address:** |  | **Postcode:** |  |
| **Home telephone:** |  |
| **Mobile telephone:** |  |
| **Email address:** |  |
| **School Attending:** |  | **Year Group:** |  |
| **Age:** |  |

**Emergency Contact Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Emergency Contact:** |  | **Relationship to Young Person:** |  |
| **Address of Emergency Contact (if different from young person):** |  | **Phone Number of Emergency Contact:** |  |

**Medical Information**

|  |
| --- |
| **Please give details of any known medical conditions, food allergies, disabilities, special requirements or any medication currently being taken:** |
|  |

**Ethnicity Key**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A** | White British | **F** | Other White | **K** | White/ Black African | **P** | Pakistani | **U** | Nigerian |
| **B** | White Irish | **G** | White/Asian | **L** | Chinese | **Q** | Bangladeshi | **V** | Somali |
| **C** | White European | **H** | Other Asian | **M** | Black African | **R** | Yemini | **W** | Latin/South Central America |
| **D** | Traveller Irish | **I** | White/Black Mixed | **N** | Other Black Background | **S** | Caribbean | **X** | Other Mixed |
| **E** | Gypsy Roma | **J** | White/Black Caribbean | **O** | Indian | **T** | Ghanian | **Y** | Other Ethnic group |
| **Z** | Prefer not to say |

**Declaration (Please Circle)** Failure to take responsibility may result in staff needing to contact other agencies involved in safeguarding children.

|  |  |
| --- | --- |
| In the case of a medical emergency, I agree to my child receiving medication recommend by the medical authorities present. We will contact you immediately and it will then be the parent/carers/guardians responsibility to talk to the medical professionals. |  YES NO |
| I understand that it is the parent/carers/guardians responsibility to collect the young person and take them home. |  **YES NO** |
| I understand that I am registering with Doncaster Council and agree that the details I have given on this form will be held on the Local Authority’s secure database. |  **YES NO** |
| I agree that Doncaster Council can send me informationabout sessions, activities and events that may be of interest to me  |  **YES NO** |
| I have read and understood the above guidance and information.  |  **YES NO** |

**To be completed by Parent/Carer/Guardian:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Print Name****(Please use capital letters)**  |  | **Relationship to young person:** |  |