



## EXMOUTH GATEWAY CLUB / EXMOUTH TIGERS



### Membership & Support Information Form

*Supporting adults with disabilities since 1989*

#### Welcome to Exmouth Gateway Club

Please complete this form as fully as possible. The information you provide helps us support members safely and ensure everyone has the best possible experience at Gateway. If any information changes during the year, please let us know.

| MEMBER DETAILS          |  |
|-------------------------|--|
| FULL NAME               |  |
| PREFERRED NAME          |  |
| DATE OF BIRTH           |  |
| ADDRESS                 |  |
| POSTCODE                |  |
| HOME TELEPHONE          |  |
| MOBILE TELEPHONE        |  |
| EMAIL ADDRESS           |  |
| MOBILE FOR TEXT UPDATES |  |

| PRIMARY EMERGENCY CONTACT |  |
|---------------------------|--|
| NAME                      |  |
| RELATIONSHIP              |  |
| MOBILE                    |  |
| TELEPHONE                 |  |

| SECONDARY EMERGENCY CONTACT |  |
|-----------------------------|--|
| NAME                        |  |
| RELATIONSHIP                |  |
| MOBILE                      |  |
| TELEPHONE                   |  |

## GP AND HEALTH PROFESSIONALS

|                                      |  |
|--------------------------------------|--|
| GP SURGERY                           |  |
| GP TELEPHONE                         |  |
| DOES THE MEMBER HAVE A SOCIAL WORKER |  |
| IF YES, NAME                         |  |
| TELEPHONE                            |  |

## MEDICAL CONDITIONS

**Please tick all medical conditions that apply and provide further details where appropriate**

| Neurodevelopmental                                     | Physical Health                                          |
|--------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> AUTISM                        | <input type="checkbox"/> ASTHMA (GIVE DETAILS BELOW)     |
| <input type="checkbox"/> ADHD                          | <input type="checkbox"/> DIABETES (GIVE DETAILS BELOW)   |
| <input type="checkbox"/> LEARNING DISABILITY           | <input type="checkbox"/> HEART CONDITION                 |
| <input type="checkbox"/> DOWN SYNDROME                 | <input type="checkbox"/> HYPERTENSION                    |
| <input type="checkbox"/> DYSLEXIA                      | <input type="checkbox"/> HYDROCEPHALUS                   |
| <input type="checkbox"/> DYSPRAXIA                     | <input type="checkbox"/> GASTRIC REFLUX                  |
| <input type="checkbox"/> FRAGILE X                     | <input type="checkbox"/> IBS / COLITIS / CHRON'S DISEASE |
| <input type="checkbox"/> EPILEPSY (GIVE DETAILS BELOW) | <input type="checkbox"/> PRADER WILLI                    |
| <input type="checkbox"/> GLOBAL DEVELOPMENT DELAY      | <input type="checkbox"/> CEREBRAL PALSY                  |
| <input type="checkbox"/> HYPOTHYROIDISM                | <input type="checkbox"/> HYPERMOBILITY                   |
|                                                        |                                                          |
| Mental Health                                          | Sensory and Communication                                |
| <input type="checkbox"/> ANXIETY                       | <input type="checkbox"/> HEARING IMPAIRMENT              |
| <input type="checkbox"/> DEPRESSION                    | <input type="checkbox"/> VISUAL IMPAIRMENT               |
| <input type="checkbox"/> BIPOLAR                       | <input type="checkbox"/> SPEECH & LANGUAGE DIFFICULTIES  |
| <input type="checkbox"/> PSYCHOSIS                     |                                                          |
| <input type="checkbox"/> PERSONALITY DISORDER          | <b>OTHER</b> (please detail)                             |
|                                                        |                                                          |

## MEDICAL INFORMATION

**Please include details of any medical conditions, allergies, medication or anything else we need to know to help us support the member safely.**

Is there a family history of SCA (Sudden Cardiac Arrest)?

☐ YES

☐ NO

If YES please give details \_\_\_\_\_

## MOBILITY & EQUIPMENT

☒ WHEELCHAIR USER      ☐ WALKING AID      ☐ HEARING AIDS      ☐ GLASSES      ☐ COLOUR BLIND

## SUPPORT NEEDS

**Please tick if the member requires assistance with any of the following**

- |                                                    |                                                     |
|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> PERSONAL CARE             | <input type="checkbox"/> EATING AND/OR DRINKING     |
| <input type="checkbox"/> TOILETING                 | <input type="checkbox"/> READING                    |
| <input type="checkbox"/> DRESSING (Buttons / Zips) | <input type="checkbox"/> WRITING                    |
| <input type="checkbox"/> MANAGING MONEY            | <input type="checkbox"/> UNDERSTANDING INSTRUCTIONS |
| <input type="checkbox"/> STAYING SAFE              | <input type="checkbox"/> SOCIAL INTERACTION         |
| <input type="checkbox"/> EMOTIONAL SUPPORT         | <input type="checkbox"/> OTHER _____                |

## COMMUNICATION

**How does the member communicate best?**

- |                                                     |                                    |                                                      |
|-----------------------------------------------------|------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> VERBAL                     | <input type="checkbox"/> MAKATON   | <input type="checkbox"/> BRITISH SIGN LANGUAGE (BSL) |
| <input type="checkbox"/> COMMUNICATION AID / DEVICE | <input type="checkbox"/> EASY READ | <input type="checkbox"/> OTHER _____                 |

## DIETARY REQUIREMENTS

- |                                                                  |                                                            |                                      |                                      |
|------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> NONE                                    | <input type="checkbox"/> VEGETARIAN                        | <input type="checkbox"/> VEGAN       | <input type="checkbox"/> GLUTEN FREE |
| <input type="checkbox"/> DAIRY FREE                              | <input type="checkbox"/> SALT RISK (TEXTURE MODIFIED DIET) | <input type="checkbox"/> OTHER _____ |                                      |
| <input type="checkbox"/> ANY FOOD ALLERGIES (NOT DISLIKES) _____ |                                                            |                                      |                                      |

## LIKES, DISLIKES, PHOBIAS AND ANYTHING ELSE WE SHOULD KNOW?

**Please tell us about the member's interests, hobbies, likes, dislikes, fears, or anything else that will help us provide the best possible experience and support during Gateway Club or Exmouth Tigers activities.**

## LIFESTYLE

**Does the member drink alcohol?**      ☐ YES      ☐ NO

If YES is there anything we should know?

Can the member swim?

☐ YES

☐ NO

If YES what level of swimmer are they ?

☐ NON SWIMMER (needs assistance in the water such as floats)

☐ BEGINNER

☐ CONFIDENT SWIMMER

☐ STRONG SWIMMER

## EMERGENCY FIRST AID

I give permission for Exmouth Gateway / Exmouth Tigers Volunteers to administer the following if required

☐ PLASTERS

☐ PARACETAMOL

☐ IMODIUM

☐ ANTIHISTAMINES

☐ APPLY ICE PACKS / COLD COMPRESS

☐ IBRUPROFEN

☐ FREEZE SPRAY / DEEP HEAT

☐ BASIC FIRST AID

☐ IN THE EVENT OF AN EMERGENCY, I AUTHORISE EXMOUTH GATEWAY CLUB / EXMOUTH TIGERS DISABILITY FOOTBALL CLUB VOLUNTEERS TO SEEK APPROPRIATE MEDICAL TREATMENT, INCLUDING CONTACTING THE EMERGENCY SERVICES IF NECESSARY.

## PHOTOGRAPHY AND MEDIA CONSENT

From time to time, photographs or videos may be taken during Gateway Club / Tigers activities to celebrate achievements and promote the club.

Please indicate whether you give permission for photographs or videos to be used

**You may withdraw your consent at any time by contacting Exmouth Gateway Club**

### MEDIA

Exmouth Gateway Club Facebook Page

☐ YES

☐ NO

Exmouth Tigers Facebook Page

☐ YES

☐ NO

Devon Ability Counts Facebook Page (football only)

☐ YES

☐ NO

Exmouth Gateway Club Instagram

☐ YES

☐ NO

Exmouth Tigers Instagram

☐ YES

☐ NO

Exmouth Gateway Club Website

☐ YES

☐ NO

Local Newspapers

☐ YES

☐ NO

Promotional Material

☐ YES

☐ NO

## DECLARATION

I confirm that the information provided on this form is accurate to the best of my knowledge.

I understand that it is my responsibility to inform Exmouth Gateway Club / Exmouth Tigers of any changes.

☐ I have read and agree to abide by the Exmouth Gateway Club Code of Conduct

☐ I have read and agree to abide by the Exmouth Tigers Disability Football Club Code of Conduct (if applicable)

**Member Signature:** \_\_\_\_\_

**Parent / Carer Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_