DofE Participant Enrolment Form

Please print clearly in CAPITALS or type your details in. You must complete all of the questions.

DofE Centre and group details (if you know them):

DofE Centre:	DofE group:

DofE level:

Bronze ☐ Silver ☐ Gold ☐
Have you registered for any previous levels of the DofE? No ☐ Yes ☐
If YES – please give the name of the DofE Centre you were registered at:
edofe ID number (if known) :

Student Personal details:

First name:	Last name:
Gender: Male ☐ Female ☐	Date of Birth: / /
Primary language English ☐ Welsh ☐ Other ☐	
Date you wish to start your DofE programme if known (enrolment date): / /	

When you first sign in to edofe you will be asked to record some personal details such as your contact details, ethnicity and personal circumstances along with details of any medical needs you may have. This data is used to enable your Leaders to support you doing your DofE programme and for the DofE's statistical and reporting purposes. You will always have a 'prefer not to say' option.

Contact details:

Parent/Carer email address	
Address (line1):	
Address (line 2):	
Town/City:	
County:	Postcode:
Telephone:	Mobile number:

Emergency contact details:

Emergency Contact name:	Relationship to you:
Emergency contact telephone number(s):	

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Declaration:
I agree to enrol as a participant on a DofE programme. I understand that I will be managing my programme using the onlineedofe system. I acknowledge that this system has a set of terms and conditions that I agree to. These terms and conditions are available at www.eDofE.org

Print Name	Signature	Date
		/ /

Consent to enrol from parent or guardian (if applicant is under 18 years old).

I agree to my son / daughter / ward doing a DofE programme. I note that it is my responsibility to check that any activity my son / daughter / ward undertakes for their DofE programme is appropriately managed and insured, unless the activity is directly managed or organised by their DofE group, centre or Licensed Organisation.

Print Name	Signature	Date
		/ /

Note:
Data supplied on this form and in edofe and information about DofE activities recorded in edofe will be used by the DofE Charity, the Licensed Organisation and DofE centre to monitor and manage DofE participation and progress by young people and manage and support Leaders. The DofE Charity will use personal data to communicate useful and relevant information to either help participants complete a DofE programme, Leaders/LOs to run DofE programmes more effectively or help the DofE Charity to improve the quality and breadth of its programmes. Occasionally the DofE Charity may send you information relating to commercial offers. If you do not wish to receive commercial information from the DofE Charity you can choose not to by amending your contact preferences in your edofe profile at any time.

For Licensed Organisation/Centre administration only:

Date registered onto edofe	/ /
Expected start date	/ /
Participant Fee received	Yes ☐ No ☐
Username	
User ID number	

eDofE participant enrolment form 2012 Version 1

PROTECT

Consent and Medical Fitness Form for Residential Visits

INFORMATION FOR PARENTS/GUARDIANS

Please complete the questions below and sign the consent. The personal and medical information requested is to ensure that a proper duty of care is possible during the residential visits.

PERSONAL DETAILS				
STUDENT		**PARENT/GUARDIAN INFORMATION**		
Surname		**Name**		
First Name		**Address**		
Tutor Group				
Address **Postcode**		**Postcode**		
		Telephone Numbers		
Date of Birth		**Day**	**Evening**	**Mobile**
Doctor		**Additional Emergency Contact**		
Surgery Address		**Name**		
		Relationship		
		Address		
Telephone No		**Telephone**		
NHS Number				
E111HC No.		**Expiry Date**		
Passport No.		**Start Date**		
		Expiry Date		

MEDICAL INFORMATION

If your child has a medical condition of any sort please discuss with your family doctor before completing the form. Medical conditions would not normally exclude your child from participating in activities. It is important that your child is accompanied by any medication necessary and that we are made aware of this. Please make sure that they have enough medication with them.

		Please Tick	
QUESTIONS		**Yes**	**No**
Has your child had any serious illness in the last two months?			
Is your child recovering from an accident, injury or fractured bone?			
Is your child a sleepwalker?			
Does your child suffer from travel sickness?			
Does your child have any incontinence problems?			
Are there any activities in which your child should not participate?			
Does your child have:	Epilepsy or convulsions		
	Diabetes mellitus		
	Asthma		
	Heart Disease		
	Any allergies		

Is your child on any medication? (if yes please give details below, including dosage and frequency)		
If the answer to any of these questions is yes please give details here:		
Has your child been inoculated against TETANUS?	**Yes**	**No**
Date of last injection if known:		
Do you consider your child to be medically fit now?	**Yes**	**No**

MEDICAL TREATMENT DURING VISITS

Young people sometimes need minor medical treatment for conditions such as headaches, rashes, pulled muscles, coughs & colds, insect bites etc. With your permission staff will treat these ailments with "off the shelf" products from a chemist. For example the following items are available: Paracetamol, muscle relaxant cream/spray, witch hazel, throat lozenges, petroleum jelly, cough mixture, antiseptic cream, calamine lotion, adhesive plasters, insect bite antihistamine.

Please indicate if you are willing for your child to be treated with "off the shelf" medication.	**Yes**	**No**
Professional help would be sought for any more serious conditions and we will contact you by telephone.		
Please indicate if you are willing for your child to undergo emergency treatment from a doctor or hospital including anaesthetic and blood transfusion should this be necessary.	**Yes**	**No**

Procedures to take in an emergency

I give my consent** for a member of staff to administer the above medication which I will deliver to the Group Leader before the visit, together with clear labels and instructions. I understand that the staff leading the visit are not qualified medical practitioners but that they will take reasonable care in the administration of the medication and will endeavour to respond appropriately should emergency treatment be required.

I give my consent** for my child to self-administer the above medication.

**** delete if not applicable.**

DIETARY INFORMATION

Does your child have any individual dietary needs (including vegetarian foods)? Please give details here.

PARENT/GUARDIAN DECLARATION

I have listed any medical or other conditions concerning my child that might affect the duty of care expected during the off-site visit.

I undertake to inform the Party Leader of any changes in the medical or other circumstances of my child before the date of departure.

I have received information about the programme and agree to his/her taking part in all the activities unless otherwise stated.

I agree to indemnify any member of staff against any claim against a member of staff by a third party, directly or indirectly, arising out of any act or fault by my child.

I agree to indemnify any member of staff involved against any costs and expenses reasonably incurred and/or other sums disbursed by a member of staff on behalf of my child during or as a result of the visit.

Signature of parent…… Date……..

Name……Relationship to participant……