



**SECTION 1 - PERSONAL INFORMATION**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Preferred Name** (for name badge): \_\_\_\_\_

**Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** (at time of RYLA): \_\_\_\_\_

**Gender:** Male      Female      Unspecified      Other

**Preferred Pronouns:** He / Him      She / Her      They / Them      Other: \_\_\_\_\_

**T-Shirt Size**    SMALL    MEDIUM    LARGE    XLARGE

**Residential Address:** \_\_\_\_\_

**Suburb:** \_\_\_\_\_ **Post Code:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Contact Phone Number:** Home \_\_\_\_\_ Mobile \_\_\_\_\_

**Occupation or Course of Study:** \_\_\_\_\_

**Employer or Educational Institution:** \_\_\_\_\_

**Can you swim:**                      No      Fair      Well

**DISTRICT 7360**





**SECTION 2 – MEDICAL INFORMATION**

*This information will be treated confidentially and will only be disclosed to organisers of the RYLA as required to ensure your safety, health and well-being.*

**Please list any special dietary requirements?**

- |                                      |                                      |  |  |
|--------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Vegetarian  | <input type="checkbox"/> Vegan       | <input type="checkbox"/> Dairy Allergy   | <input type="checkbox"/> Gluten Allergy  |
| <input type="checkbox"/> Nut Allergy | <input type="checkbox"/> Egg Allergy | <input type="checkbox"/> Seafood Allergy | <input type="checkbox"/> Halal Food Only |

Other (please specify) \_\_\_\_\_

**Do you have any existing medical conditions?** Please briefly state how they may impact on your ability to participate in the program.

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

**Are you taking any medication,** prescription or otherwise?

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

**Please state any additional information we may need to know.**

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

**Date of last Tetanus injection:** \_\_\_\_\_ **Medicare Number:** \_\_\_\_\_

**Health Insurance Provider:** \_\_\_\_\_

**Health Insurance Member Number:** \_\_\_\_\_



Rotary Youth Leadership Awards

**SECTION 3 - EMERGENCY CONTACT DETAILS**

**Contact Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Residential Address:** \_\_\_\_\_

**Suburb:** \_\_\_\_\_ **Post Code:** \_\_\_\_\_

**Contact Phone Number:** Home \_\_\_\_\_ Mobile \_\_\_\_\_

Why would you like to attend RYLA?

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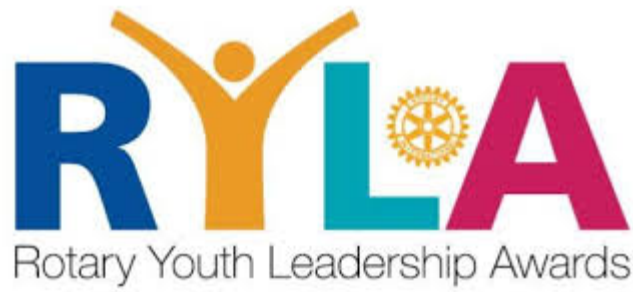
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**SECTION 4 – ABOUT YOU**

**Tell us about you and your experiences. Please write at least a paragraph.**

Who are you?

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What do you do?

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What are you passionate about?

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What leadership experience do you have?

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