ALLSORTZ

Youth Club

Supporting Young Autistic People

Full Name:

Date of Birth:

Address: .....

Telephone Number: .....

Your Interests: .....

Emergency Contact Details and Parents or Carers Names:

Email address: .....

Please tick if applicable:

Autism Spectrum Disorder/Condition
Asperger's Syndrome
High Functioning Autism
Attention Deficit Hyperactivity Disorder
Epilepsy
Asthma
Diabetes
Sensitivity to pain: High Medium Low

Other Medical Conditions: .....

Allergies..... ....

Medication..... .....

Doctors Details: .....

I agree to abide by the rules of the club and to respect all members, volunteer workers and the resources of the club. If I do not then I will be asked to leave and my membership cancelled.

Signed: ..... Date: .....

If under 18, please ask your parent, carer or guardian to sign acknowledging the above.

Signed: ..... Date: .....

Allsortz Youth Club 25 Meadow Way, Stafford, ST17 4NT

Allsortzyouthclub@yahoo .com Tel:07922149562