

HARTLEPOOL YOUTH SERVICE

MEMBERSHIP APPLICATION FORM (1/2)



ALL SECTIONS MUST BE COMPLETED IN INK & CAPITAL LETTERS

PROJECT NAME:

FOR OFFICE USE ONLY

MEMBERSHIP NUMBER:

NAME OF SCHOOL/COLLEGE/WORK:

First Name

Surname

Date of birth

D	D	M	M	Y	Y

Age

Full Address

Contact no.

Email

Emergency contact no.

Name & relationship

Gender

<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender
<input type="checkbox"/> Prefer not to say	<input type="checkbox"/> Other (Please specify):	<input type="text"/>

Ethnicity

<input type="checkbox"/> White - British	<input type="checkbox"/> White - Irish	<input type="checkbox"/> White - Other
<input type="checkbox"/> White & Black Caribbean	<input type="checkbox"/> White & Black African	<input type="checkbox"/> White & Asian
<input type="checkbox"/> Mixed - Other	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani
<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Asian - Other	<input type="checkbox"/> Caribbean
<input type="checkbox"/> African	<input type="checkbox"/> Black - Other	<input type="checkbox"/> Chinese
<input type="checkbox"/> Prefer not to say	<input type="checkbox"/> Other	

If you chose any of the 'Other' categories above, please specify:

Medical

history

(tick all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fainting	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Migraines	<input type="checkbox"/> Other (please specify):	<input type="text"/>

Please list any long-term prescribed medication currently being taken:

Please tick all that applies to you

(so we can provide better support)

<input type="checkbox"/> Disability	<input type="checkbox"/> Entitled to free school meals	<input type="checkbox"/> Looked after (in care)
<input type="checkbox"/> Young parent/Pregnant	<input type="checkbox"/> Accessing CAMHS/Counselling	<input type="checkbox"/> Young carer
<input type="checkbox"/> Special educational needs	<input type="checkbox"/> School attendance/Exclusion	<input type="checkbox"/> Asylum seeker
<input type="checkbox"/> Other		

PLEASE CONTINUE TO CONSENT TO SHARE

HARTLEPOOL YOUTH SERVICE

MEMBERSHIP APPLICATION FORM (2/2)



PLEASE TICK ALL BOXES AT THE END OF EACH STATEMENT YOU AGREE WITH

I understand that the information on this form will be held on a secure database by Hartlepool Borough Council Youth Service for the purpose of monitoring progress and outcomes for young people. The data will be held until the age of 19 and up to 25 for young people with additional needs.	<input type="checkbox"/>
I consent to the sharing of information recorded, where appropriate, with persons who have a similar role in supporting young people, including health professionals, Children's Hub, Family Support and Police where this would benefit me, and this would be discussed with me in advance.	<input type="checkbox"/>
I understand that I can withdraw this consent at any time and have the right to access information held on me. I also have the right to withdraw consent.	<input type="checkbox"/>
If any data is inaccurate, I have the right to have records amended and, in certain circumstances, deleted. If I think there is a problem with the way Hartlepool Borough Council is handling information, I can complain to the Information Commissioner's Office (ICO) via their website at ico.org.uk/concerns/	<input type="checkbox"/>
The Youth Service privacy notice, which gives more detail on the information held by the service can be accessed via the HBC website or in hard copy by asking your Youth Worker.	<input type="checkbox"/>
I consent to my photographs being taken during Youth Service Activities and for it to be used, if required, for promotional purposes and evidence of projects with Youth Services.	<input type="checkbox"/>

APPLICANT SIGNATURE :

Date :
D D M M Y Y

PARENT/CARER SIGNATURE :
(FOR APPLICANTS UNDER 16)

Date :
D D M M Y Y

PARENT/CARER FULL NAME :

DATE FORM RECEIVED :
D D M M Y Y

NAME OF STAFF MEMBER RECEIVING CONSENT :

THANK YOU