

Ripon RUFC Adult Membership

2019/2020



Personal Information		Full Member £90 <input type="checkbox"/>
Mr <input type="checkbox"/> / Mrs <input type="checkbox"/> / Ms <input type="checkbox"/> / Miss <input type="checkbox"/> / Dr <input type="checkbox"/>		Player £90 <input type="checkbox"/>
First Name:		Patron £110+ <input type="checkbox"/>
Last Name:		Social Member £45 <input type="checkbox"/>
Address:		No voting rights or access to international tickets.
Postcode:		Concessions
Home Telephone No.:		Over 65 £45 <input type="checkbox"/>
Mobile Telephone No.:		Student £45 <input type="checkbox"/>
Work Telephone No.:		Armed Forces £45 <input type="checkbox"/>
Email Address:		Please complete and return this form with payment to: Andrew Binks 30 Kingstonia Gardens Ripon, HG4 1TE andrew.binks@riponrugby.org
D.O.B: / /		Payment Options
Occupation:		Cash <input type="checkbox"/>
Skills you could provide to club:		Debit/Credit Card <input type="checkbox"/>
Parent of a registered junior player (tick if appropriate) <input type="checkbox"/>		BACS <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to Ripon RUFC, and others on its behalf, processing, by means of a computer database or otherwise, any information which I provide to them for the purpose of membership of the Club, and consent to receiving communication from the club. Ripon RUFC does not make its membership list available to any outside organisations. I confirm that I have read the Ripon RUFC rules and agree to comply with them. 		Cheque <input type="checkbox"/> (Payable to Ripon RUFC)
Signature	Date / /	

Office Use Only	Players Only In case of emergency please contact:	
Payment Received <input type="checkbox"/>	Name:	
Entered onto Database <input type="checkbox"/>	Mobile:	Phone:
First Aid File <input type="checkbox"/>	Relationship:	

Ripon RUFC Adult Player Medical Information 2019/2020

All players must complete the medical information below.



Player Name:			
Address & Postcode:			
D.O.B:			
Contact Number:			
Email:			
Emergency Contacts. Partner/Spouse info:		Secondary Contact:	
First Name:		First Name:	
Surname:		Surname:	
Relationship:		Relationship:	
Home Tel:		Home Tel:	
Mobile Tel:		Mobile Tel:	
<p>Please fill out the following to the best of your knowledge:</p>			
Do you suffer from any ongoing medical conditions (e.g. Asthma) If yes, please state condition and medication required.			
Are you allergic to anything? If yes, please state what and the medication required in the event of a reaction (e.g. Epi Pen).			
Do you suffer/have previously suffered from any other condition, which First Aiders should be aware of? (e.g. broken bone which may still be susceptible to injury).			
Signature:			
Print Name:			
Date:			