



# GARDA WESTMANSTOWN GAELS GAA CLUB

[www.gardawestmanstowngaels.com](http://www.gardawestmanstowngaels.com)

## MEMBERSHIP FORM 2016

**Name Player/Adult 1:** \_\_\_\_\_ **Name Player/Adult 2:** \_\_\_\_\_

**Name Player/Adult 3:** \_\_\_\_\_ **Name Player/Adult 4:** \_\_\_\_\_

Please indicate if a Child (C) or Adult (A) membership is being applied for.

**Cost: Family Membership €250, 1<sup>st</sup> Child €90, Each subsequent child €60 each, Adult Member €50**

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

**Date of Birth:** 1) \_\_\_\_\_ 2) \_\_\_\_\_

(N/A for Adults) 3) \_\_\_\_\_ 4) \_\_\_\_\_

**Team Mentor:** \_\_\_\_\_

**School:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_

**Contact telephone Number(s):** \_\_\_\_\_

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

I/we agree to the club terms of membership and to the club code of conduct. I/we undertake not to bring the club or the GAA into disrepute. I/we understand that all members must wear gum shields for both training and matches. I/we understand that all members must wear the appropriate gear. I/we understand that the club may from time to time, use photographs of players within the context of club activities for public viewing on a variety of media and that any parent who wishes for their child's image not to be utilised in this way must notify the club / child protection officer of this. I understand that if such a request is not received the club will presume full permission has been agreed. (As always normal child protection protocols will apply in any and all such publicity). I consent to the Club using the information provided in this form for the proper administration of the club and your membership including the use of your email address and telephone number to distribute information about club events and activities.

**Signed Player/Adult 1:** \_\_\_\_\_ **Signed Player/Adult 2:** \_\_\_\_\_

**Signed Player/Adult 3:** \_\_\_\_\_ **Signed Player/Adult 4 :** \_\_\_\_\_

**Signed Parent/Guardian:** \_\_\_\_\_

**Signed: (Club Officer)** \_\_\_\_\_

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Official Use:

The sum of € \_\_\_\_\_ was received and paid in cash/by cheque. (Please make cheques payable to Garda GAA Club)

The fee received is in respect of \_\_\_\_\_ juveniles, \_\_\_\_\_ Adult members, \_\_\_\_\_ Committee member/mentors

## Stay Active – Have Fun – Play Gaelic

Garda Westmanstown Gaels GAA Club, Garda GAA Grounds, Westmanstown Sports Complex, Westmanstown, Dublin 15



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## GIVE RESPECT – GET RESPECT

### Code of behaviour for members

#### Players Should Always:

Play Fairly, do their best and enjoy themselves

Respect fellow team members regardless of ability, cultural or ethnic origin, gender, sexual orientation of religious beliefs

Support fellow team members regardless of whether they do well or not

Represent their team, their club and their family with pride and dignity

Respect all coaches, Referee's and officials and their decisions

Be gracious in defeat and modest in victory

#### Parents/Guardians Should Always:

Respect referee's/officials decisions and encourage children to do likewise

Never admonish your own child or any other child for their standard of play

Show approval for effort, not just results

Never embarrass a child or use sarcastic remarks towards a player

Applaud good play from all teams

Signed Player/Adult 1: \_\_\_\_\_

Signed Player/Adult 2: \_\_\_\_\_

Signed Player/Adult 3: \_\_\_\_\_

Signed Player/Adult 4: \_\_\_\_\_

Signed Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## BE THE BEST YOU CAN BE

### MEDICAL CONSENT

Name Player 1: \_\_\_\_\_ Name Player 2: \_\_\_\_\_

Name Player 3: \_\_\_\_\_ Name Player 4: \_\_\_\_\_

School: \_\_\_\_\_

1. Does your child have any medical condition that our Coaches/Mentors should be made aware of?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES Please specify \_\_\_\_\_

2. Does your child have any allergies that our Coaches/Mentors should be made aware of?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES Please specify \_\_\_\_\_

3. Does he/she take any medication?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES Please specify \_\_\_\_\_

I give permission for my child to be brought to hospital if necessary YES \_\_\_\_ NO \_\_\_\_ . Should it be deemed that due to medical considerations, that my child would require constant supervision, it shall be my responsibility to provide qualified adult cover.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Home address: \_\_\_\_\_  
\_\_\_\_\_

Contact Tel No's: Primary \_\_\_\_\_ Secondary: \_\_\_\_\_  
(Contact name of person if different from primary)

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