MEDICAL INFORMATION FORM

Please complete this form as accurately as possible. The information you disclose will be confidential and will only be used to help staff respond to injury and illness.

Name: _____

Address: _____

_____ Postcode: _____

Contact No.: (b/h): _____ (a/h): _____ (mobile): _____

Gender: ❒ Male ❒ Female Date of Birth: _____

In case of emergency, please contact:

Name: _____ Relationship: _____

Contact No.: (b/h): _____ (a/h): _____ (mobile): _____

Doctor's Name: _____ Doctors Phone No.: _____

Do you suffer from any of the following conditions? If so please ✓ and list dose medication frequency and usage:

	MEDICATION		MEDICATION
❒ Arthritis		❒ Diabetes	
❒ Asthma		❒ Bleeding conditions	
❒ Epilepsy		❒ Kidney Disease	
❒ Heart Disease		❒ High blood pressure	
❒ Fears and/or phobias		❒ Drug Allergies	
❒ Other (please state)			

Has Paddle Australia been notified of any prescribed medications being taken?	❒ No	❒ Yes	Date:	
Have you had a tetanus Toxin injection?	❒ No	❒ Yes	Date:	
Do you have any disabilities?	❒ No	❒ Yes	Condition:	
Can you swim?	❒ No	❒ Yes	Distance:	
Any Allergies (eg: Bee Stings)	❒ No	❒ Yes	Allergy:	
Food Allergy	❒ No	❒ Yes	Foods:	
Do you have any specific dietary requirements?	❒ No	❒ Yes	Requirements:	
Do you have any injuries eg Shoulder, Back	❒ No	❒ Yes	Describe:	
Please state any other information you feel may need to be known:				
Please state any medications that may be required:				

If I sustain an injury or illness whilst participating, I authorise the appointed Medical Staff to perform and administer emergency medical attention as they think as necessary.

Medicare No: .....

Name: ..... Date: .....

Signature: .....

(Parents signature if U/18)