Medical details checklist 2013

SURNAME: _____ GIVEN: _____ M F

ADDRESS: _____

TELEPHONE: (H) _____ (M) _____ D.O.B: / /

CONTACT PERSON: _____ RELATIONSHIP: _____

TELEPHONE: (H) _____ (W) _____

G.P. _____ TELEPHONE: _____ AMBULANCE COVER Y / N

CHECKLIST (if yes, describe next to category)

Y / N Abnormal Blood Pressure _____ Y / N Neurological Condition _____

Y / N Cardiovascular Condition _____ Y / N Epilepsy_____

Y / N Respiratory Condition _____ Y / N Joint Surgery _____

Y / N Diabetes _____ Y / N Visual Impairment _____

Y / N Hearing Impairment _____ Y / N Contagious Diseases _____

CURRENT MEDICATIONS: (inc. asthma medication) If more space needed, list on back of page.

Medication Name	Condition Taken For	Known Relevant Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there any other significant medical history or relevant information that may affect treatment in an emergency situation or preclude involvement in any activity (including joint problems)? _____

_____

_____

_____

This form is confidential and will only be used to assist in a medical emergency. As a member of the Fencing SA State Squad I understand that it is my responsibility to complete this form annually and / or if there is any change to my health status. If under 18 years of age, this form must be signed by a parent / guardian.

Printed Name: _____ Signature: _____ Date: / /