PERSONAL MEDICAL HISTORY

NAME IN FULL:

ADDRESS:

POSTCODE:

Date of Birth:	Next of Kin:
Home Phone:	Relationship:
Work Phone:	Address:
Mobile:	
Email:	Emergency phone number:

MEDICARE / PRIVATE HEALTH FUND DETAILS

Medicare Number:	Do you have Private Health Insurance?
Fund Name:	Membership Number:

MEDICAL PRACTITIONER DETAILS:

Doctor's Name:	Address:
Phone Number:	
Dentist's Name:	Phone Number:

CURRENT MEDICATIONS - Please list any medications you are taking.

Have you checked the above medications with the World Anti-Doping Code Prohibited List*? YES / NO (Please circle)

If Applicable: Do you have an ASADA approved ATUE (Abbreviated Therapeutic Use Exemption) or TUE*? YES / NO (Please circle)

*Check www.asada.gov.au for more information

ALLERGIES:

Drugs:	Food:

Other: e.g sticking plaster

PREVIOUS MEDICAL HISTORY: - Answer yes / no and list details.

Asthma:	Diabetes:	Type:
Blood Pressure:	Epilepsy:	
Blood Clots:	Bleeding Disorder:	

Will you accept a blood transfusion if required?

Do you wear glasses / contact lenses when playing?

Have you suffered fractures / dislocations in the past?

Have you ever had a cardiac condition?

PREVIOUS SURGERY - List details and any complications:

The above is true and accurate and I give permission for this information to be given to medical personnel in case of an emergency.

Signed:	**Date:**

ALL PERSONAL MEDICAL DETAILS WILL BE KEPT IN THE STRICTEST CONFIDENCE