

Player Medical Form



PLAYER DETAILS			
Surname			
Given Name/s			
Street Address			
Date of Birth			
Medicare Number			
Ambulance Cover No.			
Private Health Cover Name & No.			
Parent/Guardian Name/s			
Email Address			
Phone No.		Mobile No.	
Emergency Contact Name			
Emergency Number			

PLEASE CIRCLE **YES** OR **NO** WHERE APPROPRIATE

1. Do you suffer from any of the following;					
Asthma	YES	NO	Diabetes	YES	NO
Allergies	YES	NO	Cardiovascular (Heart) disease	YES	NO
Migraine Head Aches	YES	NO	Epilepsy	YES	NO
2. Do you take any medication regularly or for emergency use? If YES, please provide details;					
3. Do you wear an oral insert (dentures, braces etc)?		YES	NO		
4. Do you wear contact lenses?		YES	NO		
5. Have you suffered any major illness or injury in the last 12 months?					
If YES, please provide details;					

6. Do you have any injuries/medical conditions that the coaches\trainers should be aware of? If so, please provide details;

7. Will you be bringing any medicine or other forms of treatment with you that the coaches\trainers should be aware of? If so, please provide details;

8. Are there any foods/drinks that you MUST have? If so, please provide details;

9. Are there any foods / drinks that you MUST NOT have? If so, please provide details;

Is there anything at all not covered in these pages, which the coaches\trainers should be aware of? If so, please provide details;

Player/Parent/ Guardian Name:
Player/Parent/ Guardian Signature:
Date:

Please return to the Registrar for their reference