

ATHLETE MEDICAL HISTORY FORM

NAME OF ATHLETE: _____ DATE OF BIRTH: _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____

Relationship to athlete: PARENT/CAREGIVER/OTHER (specify): _____

Phone numbers: DAY EVENING MOBILE _____

ALTERNATIVE CONTACT:

Name: _____

Relationship to athlete: PARENT/CAREGIVER/OTHER (specify): _____

Phone numbers: DAY EVENING MOBILE _____

RELEVANT MEDICAL HISTORY

Medical Conditions: (e.g. asthma, diabetes)

Medications: (prescribed and/or over the counter)

Allergic Reactions:

Vaccinations:

When did you receive your last Tetanus vaccination? Date: _____ (month/year)

Previous Injuries:

<i>Injury</i>	<i>Date</i>	<i>Treatment</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Conditions: (e.g. contact lenses, braces)

I consent to the collection of the above details for use should any medical treatment be required for an injury or condition I may sustain while involved in activities related to my sport. I acknowledge my right to access and correct this information. This consent is given in accordance with the Privacy Act 1993.

Signed: _____
(Parent/Caregiver to sign if athlete is under 18 years of age)

Date: _____