MEDICAL FORM & FIRST AID TREATMENT

Enter the Year:

Participant Details (separate form must be completed for each participant):

Team (Tinies/Sub-Juniors/Juniors/Intermediates/Seniors/Masters)	**Enter an age group**
Family Name:	Given Names:
Date of Birth:	Medicare Number:

Family Doctor Details

Doctor:	Phone No.:
Practice Address:	

MEDICAL CONDITIONS

Does your child suffer any of the following conditions listed below? Please circle or select those that apply.

Allergies Yes or No **Anaphylaxis** Yes or No

Please specify nature of all allergy conditions including specific details of food allergies and intolerances and indicate if anaphylactic reactions apply to these. Please use reverse of this form if additional space required.

Heart Condition	Yes or No	Nose Bleeds	Yes or No
Asthma	Yes or No	Phobias	Yes or No
Diabetes	Yes or No	Respiratory Condition	Yes or No
Drug Allergy	Yes or No	Sleep disturbances	Yes or No
Epilepsy	Yes or No	Travel sickness	Yes or No

Other Yes or No If yes, please specify:

If you answered YES to any of the above please complete a Care Plan on reverse of this page.

MEDICAL CONSENT (must be signed by person 18 years+)

☐ **Medical Consent**: I consent to medical treatment and ambulance transport being sought in an emergency, either for my child/children or myself, and I agree to pay any costs incurred.

Participant/Parent/Guardian: Name **Signature** **Date**

INJURY/ILLNESS DECLARATION (must be signed by person 18 years+)

I agree that it is my responsibility to ensure that myself/my child is fit and healthy prior to attending practice or competition. I agree to provide prompt advice and information to the Team Manager if there are any changes in my/my child's health status which may affect my/my child's capacity to attend class and/or perform a strenuous physical sport like calisthenics (for example, poor health, fatigue, epilepsy, weakness in limbs, pain with some movements, coordination, concentration, confidence, back condition, any past back, bone or muscle injury etc). Where necessary I will provide the team Manager and Head Coach with a medical certificate clearing myself/my child to perform.

Participant/Parent/Guardian: Name **Signature** **Date**

FIRST AID DECLARATION (must be signed by person 18 years+)

I agree that it is my responsibility to provide an instant ice pack for myself/my child for each class for use as **temporary pain relief if required. I also consent to non-prescription pain relief, such as Nurofen or Panadol,** being administered to my child in consultation with the coach and team manager if required.

Participant/Parent/Guardian: Name **Signature** **Date**

PLAN FOR EXISTING MEDICAL CONDITIONS

Please give details below of the action/care required for any medical conditions listed on the previous page. Information should be as detailed as possible and include information on the use of devices such as Epi Pens, inhalers, insulin pumps, as well as information on medication or any other treatment details. A formal Care Plan completed by a medical practitioner MUST be provided where First Aid treatment could include the use of such devices with details for admistrating the treatment.

Please advise if the participant is able and authorised to self-administer any medication(s) and if Yes please also include which condition(s) this applies to.

Where possible a formal Care Plan completed by a medical practitioner should be attached e.g. Asthma Plan.

Participant/Parent/Guardian Name:.....Signature:.....Date:.....