CHERRYBROOK SENIOR & LITTLE ATHLETICS CLUB INC.

MEDICAL FORM

FAMILY NAME:	GIVEN NAMES:	
Date of Birth:	Age Group:	Gender: M/F

Please complete the relevant boxes below to advise of any medical conditions. If you need more space please use the reverse side of this form.

Does the member suffer from any of the following:	Yes	No	Please specify level of reaction	Please specify action to be taken/treatment to be given
Asthma?			Mild ☐ Severe ☐ If severe, please detail an action plan or attach a copy of any official action plan.	
Will they have an inhaler with them at Little Athletics?				
Allergies?			If yes please specify what to: ***Level of reaction:*** Mild ☐ Severe ☐	If reaction is severe please attach a copy of any ascia action plan held.
Do they need an epipen?			If yes please ensure that they have one with them.	
Epilepsy?				
Diabetes?				
Migraines?				
Fainting or dizzy spells?				
Any other conditions?				

Date of last tetanus: ___/___/___ or unknown ☐

Medicare Number: ☐☐☐☐ ☐☐☐☐☐☐

Do you give permission for the organisers to seek emergency medical treatment if required? YES / NO

Any conditions to your permission? _____

Parent/Carer's Signature:_____ **Date:**_____

Parent/Caregiver's Name:_____*(pls print)*

Friday night Emergency Contact Name:_____ **Contact Number:** _____

Alternative Emergency Contact Name:_____**Number:**_____