

# WARRENDER BATHS CLUB MEDICAL FORM

SURNAME: ..... FORENAME: .....

ADDRESS .....

.....

DATE OF BIRTH: .....

DOCTOR'S NAME: .....

DOCTOR'S ADDRESS: .....

EMERGENCY TELEPHONE CONTACT NUMBERS:

Contact Person 1

Name .....

Mobile Number.....Work Number..... Home Number .....

Contact Person 2

Name.....

Mobile Number .....Work Number.....Home Number.....

## MEDICAL INFORMATION

1. Do you suffer from any allergy e.g.. drug, foodstuff, animals? YES/NO  
If YES, give additional information.

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2. Have you been immunised against tetanus? YES/NO If YES, give  
approx.date.....

3. Do you suffer from travel sickness? YES/NO

4. Do you suffer from any recurring illness such as asthma? YES/NO  
If YES, give additional information.

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5. Do you.....

a. Take regular medication for any reason, e.g. asthma, epilepsy, migraine etc.? YES/NO  
If YES, give additional information.

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b. Require injections for diabetes? YES/NO  
c. Use an inhaler or nasal spray? YES/NO  
d. Use any other medication at present? YES/NO

If YES, give additional information.

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6. Undergoing investigation in hospital, or on the waiting list for hospital treatment?  
YES/NO  
If YES, give additional information.

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7. Do you have health insurance (for travel abroad)? Please state EHIC (and provide EHIC number and expiry date) or private insurance.....

8. Please attach a note of any special care you might need to take while we are at competitions etc, including any special dietary requirements.

Note any medicines to take with dosage and times

Name of medicine: .....

Dose /or doses: .....

Time of day to be given: .....

9. To the best of your knowledge, have you been in contact with any contagious or infectious disease or suffered from anything in the last four weeks that may be or become contagious or infectious? YES/NO If YES, please give brief details:

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**FOR PLAYERS 16 YEARS OF AGE AND OVER** - If I require medical care during the trip / competition and if, in the opinion of the doctor dealing with the case, medical or surgical treatment is required, then I hereby give to the leader(s) of the tour group permission to sanction such treatment if contact cannot be made with either of the 2 people mentioned in the emergency contact section.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR PLAYERS UNDER THE AGE OF 16 –**

A. If my daughter / son should require medical care during the trip / competition and if, in the opinion of the doctor dealing with the case, medical or surgical treatment is required, then I hereby give to the leader(s) of the tour group permission to sanction such treatment **IF ANY OF THE AFOREMENTIONED PERSONS CANNOT BE CONTACTED AT THE TIME TO GIVE THE NECESSARY PERMISSION**, and

B. I consent to my daughter/son being allowed to sign out of the team for limited periods of time at the Team Manager's discretion in accordance with the foregoing provisions of the Code of Conduct.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_