

SCHOOL SPORT ACT ATHLETE MEDICAL INFORMATION FORM

STUDENT DETAILS

Surname: _____ Given Names: _____

Address: _____

Suburb: _____ Post code: _____

Date of birth: _____ School: _____

STUDENT MEDICAL DETAILS

Medicare No.: _____ Exp Date: _____ Ambulance Fund: _____

Private Health Fund: _____ Fund number: _____

NOTE: School Sport ACT Representative Athletes are covered by a limited insurance policy during officially organised training, games and functions. A summary of the policy coverage is available from Team Officials.

Family doctor: _____ Phone number: _____

Please tick if your child suffers any of the following:

- | | | | | |
|--------------------------------------|---|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Reaction to drugs |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Eczema | <input type="checkbox"/> Fits or blackouts | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Other |

If you ticked any boxes above please give details: _____

Date of last Tetanus injection: _____ Is the student presently taking any medication?: Yes No

If Yes, please state name of medication, dosage, etc: _____

NOTE: School Sport ACT Officials must be informed about the management of any medication prior to leaving for an event. Arrangements need to be agreed on the transport, storage and administration of medication. In all cases medication must be labeled with the students name, dosage and frequency of administration.

Do you consent to the student receiving paracetamol (eg Panadol, Dymadon) for temporary pain relief, high temperature or fever?
Yes No

Emergency contact name: _____

Relationship: _____

Home phone number: _____ Work phone number: _____

Consent to medical attention: In the case of an emergency, I authorise the Team Officials to arrange for the student to receive such medical or surgical treatment as may be deemed necessary.

Signed: _____ Parent/Guardian Date: _____

Home phone number: _____ Work phone number: _____

This form requests information about students that will be held in confidence by the Team Officials. This information may be disclosed to medical or para-medical staff and other relevant officers in the event of an accident or emergency. The information is collected as a lawful administrative function of the ACT Schools Sports Council.