

Health Statement

NAME: _____		Preferred Name: _____	
HOME ADDRESS: _____			
Suburb: _____		Postcode: _____	Telephone No: _____
PERSONAL: Date of Birth: _____	Gender: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female
Membership Number: _____	Ancillary Benefits Cover: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare Number: _____	Ambulance Ins Number: _____		
Private Health Insurance: _____	Private Health Ins Number: _____		
EMERGENCY USE: Details of the Parents / Guardians for emergency contact			
NAME: _____		Relationship: _____	
ADDRESS: _____			
Suburb: _____		Business: _____	Home: _____
Postcode: _____	Father's Mobile: _____	Mother's Mobile: _____	
HEALTH STATEMENT			
If the person named on this form suffers from any chronic or recurrent ailment, allergy or physical capacity, it should be disclosed in order that provision can be made for their welfare.			
A Do they suffer from any physical or other disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify: _____ _____	
B Do they suffer from: Asthma? Severe / Mild Diabetes? Type 1 / Type 2 Epilepsy? Severe / Mild Dizzy Spells or Blackouts? Bed Wetting? Sleep Walking? Travel Sickness? Migraine Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation / Medication: _____ _____ _____ _____	
C Do they have any allergies ? I.e. Penicillin, bee sting, bites, egg, hay fever, other food, drug or other environment allergy.	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify: _____ _____	
D Do they have any medications regularly? I.e. Injection / tablet / capsule Penicillin, insulin, Ventolin, other drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Drug: _____ Dosage: _____ Reason or Cause: _____ How often Administered: _____ Administered by Whom: _____	
E Is there any further information you may consider necessary, about which we have not asked above and of which we should be aware? Including special diets ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ _____			
F Analgesics: In the event of your child requiring administration of an analgesic (e.g. Panadol); do you HEREBY CONSENT to your child being given the recommended child dosage of a Paracetamol or Panadol? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please sign here: _____			
G Details of last Anti-Tetanus injection: Year of Original Injection: _____ Year of last booster injection: _____			

I hereby **authorize** the Leader in Charge, in circumstances where it is not possible or is impractical to communicate with me, to seek for my child, such Surgical, Medical or Dental treatment as a qualified Surgeon, Medical or Dental Practitioner may consider being necessary (including transfusion of blood) and I hereby **Consent** to such treatment.

Date: _____ **Signed:** _____ (Parent / Guardian)