



CONFIDENTIAL

PARTICIPANT MEDICAL FORM

IMPORTANT INFORMATION.

This form will be copied and the original will be given to the medical director on the event, the event director or his nominated official will carry the second copy. The information provided will be if required, given to any Ambulance / Medical personnel that may at any time during the event be required to treat / transport you. On completion of the event these documents will be destroyed. If you wish to have the forms returned to you please inform the event medical director and the event director of your request. All care will be taken however NO responsibility will be taken for false or incorrect information given on or omitted from this form.

Personal details:

Team or Car Number _____
Name: _____
Surname / Family Name Given Names

Preferred Name: _____ DOB: _____ / _____ / _____
Date of birth Day Month Year

Residential address: _____
Number and Street / Road name

Suburb / Town State Post Code

Postal address: _____
Post Office Box Number / Number and Street name

Suburb / Town State Post Code

Medicare number: _____ Valid to _____ / _____
Month Year

Do you have Private Health Insurance? Yes / No

If yes provide details: _____
Company Policy Number

If you are on a Pension or have a Senior Card or Health Care Card please provide number on card and type of card: _____
Card Number Type of card

Next of kin details:

This is the person legally nominated by you as your next of kin. This person may or may not be with you on this event. It may be a spouse, parent, child, sibling, or any person nominated by you. This person does not have to be notified in case of emergency if you so wish.

Name: _____
Surname / Family Name Given Names

Relationship to you: _____

Contact details: _____
Day time phone number After hours phone number Mobile phone number

Do you wish this person notified in case of emergency? Yes / No

Emergency contact person:

This is a person nominated by you as a contact in case of emergency. This person must not be travelling with you on this event and should be a person not on this event. If this is the same person as your next of kin please write AS ABOVE in the Name section.

Name: _____
Surname / Family Name Given Names

Relationship to you: _____

Contact details: _____
Day time phone number After hours phone number Mobile phone number

Private Doctor details: (optional)

Contact details of your private General Practitioner (Doctor) and Specialists.

Doctors Name: _____ Contact Phone: _____

Specialists Name: _____ Contact Phone: _____

What condition do you see this person for? _____

Specialists Name: _____ Contact Phone: _____

What condition do you see this person for? _____

PERSONAL MEDICAL DETAILS

Current medical details:

Please list below any current medical conditions that you have had in the past six months or are suffering from currently. Eg. Asthma, Diabetes, Epilepsy, Cardiac conditions, Blood pressure problems, Surgical procedures, Broken / Fractured bones.

Current medications:

Please list below all current medications that you are taking. This includes contraceptive pills, asthma puffers, insulin/nova pens, Anginine/GTN spray or any other prescribed medication however regularly/irregularly taken.

Medication Name of drug/medication on packet	Amount taken Dosage taken each time you take medication Eg 2 x 0.4mg tablets.	How often How often do you take this medication Eg. 3 x daily or only as required.

Other relevant medical details:

Please list below any relevant previous medical conditions / surgery. Eg. Cardiac surgery, Spleen removed, Major fractures / broken bones requiring surgery eg Hip replacement, Collapsed lung/s, significant trauma, Medical conditions.

ALLERGIES

Drug allergies:

Please list below any known drug allergies/reactions and the reaction you have (if known). Eg Allergic to Penicillin Causes itching and skin rash.

DRUG	Reaction (if known)

Food Allergies:

Please list any known food allergies/reactions and the reaction you have (if known). Eg. Bananas, Severe anaphylactic reaction/choking.

FOOD	Reaction (if known)

Do you carry emergency medication for this allergy? Yes / No.

ALLERGIES Continued

Other Allergies:

Please list any other known allergies/reactions you have and the reaction you have (if known). Eg Hairy caterpillars, Skin rash.

ALLERGY	Reaction (if known)

Do you carry emergency medication for this allergy? Yes / No.

OTHER MEDICAL INFORMATION

Please list below any other information you feel may be of assistance to you in case of an emergency. Eg To remove artificial leg please undo buckle at top above knee first.

Signed: _____ Dated ____/____/____