



MEDICAL FORM		CAR No.
2020	VERSION 3	?

Personal details:

Please provide us with a little information about yourself that could prove to be vitally important in the case of an emergency.

FULL NAME: **DATE OF BIRTH:**

RESIDENTIAL ADDRESS:

 POSTCODE:

POSTAL ADDRESS:

 POSTCODE:

Use 'DITTO' if as above.

DRIVER'S LICENCE NUMBER: **STATE:** **VALID TO:**

MEDICARE NUMBER: **VALID TO:**

PRIVATE HEALTH COVER: **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:**

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 parent, spouse, child, sibling or anyone nominated by you. This person does not have to be notified in case of an emergency.

FULL NAME: **PREFERRED NAME:**

RELATIONSHIP TO YOU:

PHONE: H: W: M:

DO YOU WISH THIS PERSON NOTIFIED IN CASE OF AN EMERGENCY? **YES** **NO**

Emergency contact person:

This is a person nominated by you as a contact in case of an emergency. This person **MUST NOT** be travelling with you on this event and **SHOULD NOT** be a person on this event. If this is the same person as your Next of Kin please write AS ABOVE in name section.

FULL NAME: **PREFERRED NAME:**

RELATIONSHIP TO YOU:

PHONE: H: W: M:

FULL NAME:

CAR No:

Private Doctor Details: (Optional)

DOCTOR'S NAME: PHONE No:

SPECIALIST'S NAME: PHONE No:

What condition do you see this person for?

SPECIALIST'S NAME: PHONE No:

What condition do you see this person for?

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 or Fractured Bones Etc.

MEDICATION
Name of drug/medication on packet

AMOUNT TAKEN
Dosage taken each time you take medication

HOW OFTEN
How often do you take this medication?

Other relevant medical details:

Please list below any relevant previous medical conditions / surgery. Eg. Cardiac surgery, Spleen removed, Major fractures / Broken bones requiring surgery, Hip replacement, Collapsed lung/s, Significant trauma etc.

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 below any known food allergies / reactions and the reaction you have (if known). Eg Allergic to Bananas - causes severe anaphylactic reaction / choking.

FOOD

REACTION (if known)

Do you carry emergency medication for any allergies? YES NO

Please detail any medication that you will need to carry.

Do you have spare medication for our Medical Officer to carry? YES NO

Spare medication provided will be carried in a refrigerated container and returned at the end of the event.

FULL NAME:

CAR No:

ALLERGIES continued...

Other Allergies:

Please list below any known food allergies / reactions and the reaction you have (if known). Eg Hairy caterpillars - causes severe skin rash.

ALLERGY

REACTION (if known)

Do you carry emergency medication for any allergies? YES NO

Please detail medication.

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 - undo buckle at top above knee first.

VEHICLE INFORMATION

Please list below details of the vehicle you will be travelling in **IF YOU ARE THE DRIVER / OWNER / RENTER.**

Please list **ONLY** the registration number of the vehicle you will be travelling in **IF YOU ARE A PASSENGER**

MAKE: MODEL: YEAR:

REGISTRATION NUMBER: REGISTRATION EXPIRY DATE:

HOW MANY PEOPLE (TOTAL) ARE TRAVELLING IN THIS VEHICLE INCLUDING YOURSELF?

CAR No:

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. No responsibility will be taken for false or incorrect information given or omitted on this form. <p style="text-align: right;">PLEASE ADD ANY OTHER INFORMATION YOU BELIEVE TO BE IMPORTANT ON A SEPERATE SHEET.</p>