PERSONAL MEDICAL HISTORY

NAME IN FULL:	
ADDRESS:	
POSTCODE:	
Date of Birth:	Next of Kin:
Home Phone:	Relationship:
Work Phone:	Address:
Mobile:	
Email:	Emergency phone number:
MEDICARE / PRIVATE HEALTH FUND DETAILS	
Medicare Number:	Do you have Private Health Insurance?
Fund Name:	Membership Number:
MEDICAL PRACTITIONER DETAILS:	
Doctor's Name:	Address:
Phone Number:	
Dentist's Name:	Phone Number:
CURRENT MEDICATIONS - Please list any medications you are taking.	
Have you checked the above medications with the World Anti-Doping Code Prohibited List*? YES / NO (Please circle)	
If Applicable: Do you have an ASADA approved ATUE (Abbreviated Therapeutic Use Exemption) or TUE*? YES / NO (Please circle)	
*Check www.asada.gov.au for more information	
ALLERGIES:	
Drugs:	Food:
Other: e.g sticking plaster	
PREVIOUS MEDICAL HISTORY: - Answer yes / no and list details.	
Asthma:	Diabetes: Type:
Blood Pressure:	Epilepsy:
Blood Clots:	Bleeding Disorder:
Will you accept a blood transfusion if required?	
Do you wear glasses / contact lenses when playing?	
Have you suffered fractures / dislocations in the past?	
Have you ever had a cardiac condition?	
PREVIOUS SURGERY - List details and any complications:	
The above is true and accurate and I give permission for this information to be given to medical personnel in case of an emergency.	
Signed:	**Date:**
ALL PERSONAL MEDICAL DETAILS WILL BE KEPT IN THE STRICTEST CONFIDENCE	