

## Medical Form for the FATHER OR SIGNIFICANT OTHER

Emergency Contact	Telephone Number (s)
1.	
2.	

Your Name: \_\_\_\_\_ School: \_\_\_\_\_ Program Date: \_\_\_\_\_

**Medicare Number:** \_\_\_\_\_

Number on card: \_\_\_\_\_ Card Expiry Date: \_\_\_\_\_

Are you covered by **Private Insurance** for hospital treatment? YES  NO

Are you covered by an **Ambulance** subscription or insurance? YES  NO

Have you received a complete course of **Tetanus** immunisations? YES  NO

Date of last booster injection: \_\_\_\_\_

Do you have any medical condition / health problem / allergy that may affect you? YES  NO

If "YES" – Please give details:  
 \_\_\_\_\_  
 \_\_\_\_\_

Treatment required if needed:  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you aware of any **Potential Medical Emergency Allergies** that may affect you? YES  NO

Details of Emergency:  
 \_\_\_\_\_  
 \_\_\_\_\_

How can we recognise the emergency?  
 \_\_\_\_\_  
 \_\_\_\_\_

How could it be prevented/avoided?  
 \_\_\_\_\_  
 \_\_\_\_\_

Treatment required in an emergency:  
 \_\_\_\_\_  
 \_\_\_\_\_

Is it necessary for you to take medication as part of the treatment for your medical condition? YES  NO

Details:  
 \_\_\_\_\_  
 \_\_\_\_\_

What is your current swimming ability?      Non      Weak      Competent      Strong

FOR EMERGENCY USE ONLY		
Name of Family Doctor	Address of Family Doctor	Telephone Number
Name of Medical Specialist	Address of Medical Specialist	Telephone Number