SAMPLE MEDICAL INFORMATION FORM

*Trip:*_____ *Dates:* _____ *Venue:* _____

Name_____ Date of Birth_____ Address_____

City_____ P/code_____ Phone H_____ W_____

Email_____

Emergency Contact: (while on trip)

Name_____ Relationship_____ Ph_____

Alt Contact_____ Relationship_____ Ph_____

Medical Information

1. Are you covered by private medical insurance? Y/ N

*Name of Fund*_____

2. Are you covered by Ambulance subscription? Y/ N

3. Medicare Number

4. Do you have/ have you had asthma? Y/ N

*Prevention*_____ *Severity*_____ *Treatment*_____

5. Do you require Medication? Y/ N

*Name of Medication*_____

*Reason*_____ *When is it taken*_____

6. Do You have any Allergies? Y/ N

*To What?*_____ *Reaction*_____ *Treatment*_____

7. Have you has major surgery or illnesses? Y/ N

*If so, when?*_____ *Details*_____

8. Do you have any other medical conditions that may affect your participation in this activity? Y/ N

*Details*_____

9. Fitness Ability (please circle)

poor fair good excellent

I .....understand the nature of the activity and the risks in the activity. These include and are not exclusive to drowning, broken limbs, twisted & damaged joints through falling or being fallen on, animal bites including snakes, injury through exposure to weather, burns & cuts through stove use & other possibilities.

I understand anything I do on this event is my own responsibility. I understand I will not be forced to do anything I do not wish to do.

Signature: Date ____/____/____