



# BRISBANE BARRACUDAS WATER POLO INCORPORATED MEDICAL FORM

## NAME

NAME: ..... DATE OF BIRTH: .....

## MEDICAL DETAILS

MEDICARE NO: ..... CARD NAME .....

HEALTH FUND: ..... HEALTH FUND NO: .....

BLOOD GROUP: ..... ALLOWED TRANSFUSION: YES/NO

ALLERGIES: .....

ASTHMA: YES / NO

FITS (of any type): .....

MIGRAINE: .....

OTHER MEDICAL CONDITIONS: .....

DETAILS OF ANY CURRENT MEDICATION: .....

.....

.....

FAMILY DOCTOR: ..... PHONE: .....

## EMERGENCY CONTACT

NAME: ..... OR .....

ADDRESS: ..... OR .....

.....

PHONE: (P) ..... (B) ..... (M) .....

RELATIONSHIP: ..... / .....

## PARENT/LEGAL GUARDIAN CONSENT

I authorise the program co-ordinators to seek medical attention on my son/daughter behalf, if it is felt necessary by him/her and further authorise the Medical Practitioner, who may examine or treat my son/daughter, to make full disclosure to the Program Co-ordinators of any diagnosis or treatment that has been made or prescribed. I further authorise the above information to be provided to any medical practitioner where deemed necessary.

SIGNED: .....  
(Parent/Legal Guardian)

PRINT NAME: .....

DATE: .....

This form is to be securely held by the Program Co-ordinators at all times while in control of the players.

