MEDICAL FORM

SURF LIFE SAVING
SOUTH AUSTRALIA

State Team Medical Form

PERSONAL DETAILS (please complete):		
First Name:	Surname:	
Club:	Male/Female:	
Mobile:	DOB:	Age Group:
Address:		
State:	Post Code:	
E-mail:		
Parent/Guardian (if U18):	Contact Number:	
Emergency Contact:	Relationship to Applicant:	
Daytime Contact Number:	Alternative Number:	

CONSENT (Parent/Guardian if U18)

I agree that photos taken may be used by Surf Life Saving SA in annual reports or in other official SLSSA publication.

I agree to delegate my authority to the Team Management and Coaches involved. Such SLSSA personnel may take whatever disciplinary action they deem necessary to ensure the safety, well-being and successful conduct of the participants as a group, or individually.

I also authorise the SLSSA personnel to obtain medical assistance which they deem necessary should an accident occur and agree to pay all medical and dental expenses incurred.

I submit the attached health information and include details of limitations for the activity concerned. I further legally authorise qualified medical practitioners to administer an anaesthetic or carry out necessary surgical procedures if such an eventuality arises.

The information given in the attached sheets is accurate to the best of my knowledge.

Signature (Parent/Guardian if U18).. Date / /

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HEALTH INFORMATION (please complete):	
Medical Conditions	
Do you / Does your child have any medical condition/health problem/allergy that coaches should be aware of?	YES / NO
Details if YES:	
Are you aware of any medical emergency which could occur?	YES / NO
If Yes Precautions to avoid emergency:	
How to recognise emergency:	
Emergency treatment required:	
Medication	
Do you / Does your child take any prescribed medication (including inhalers)?	YES / NO
If Yes Medication Name:	Dose:
When taken:	How taken:
Side effects:	
Note: **Any medication needed should be handed to Team Management** on arrival, with written notes of name, medication, dose, etc.	
Have you / Has your child received a complete course of Tetanus Toxoid immunization?	YES / NO
Date of last booster: (Check details with your doctor if uncertain)	
Medicare/Health Fund	
If you / your child is a member of any private medical benefit fund, please provide details	
Membership Number:	Fund Name:
Benefit:	Ambulance Cover if applicable:
Any other relevant medical information (allergies, food requirements:	

NOTES

The information requested in the Health Information section will be considered confidential and will be treated accordingly and is sought in order to protect and assist you / your child so that the training / trip may be a safe and enjoyable experience. Please attach extra sheets if required and contact the Team Management to discuss any health problems