**MEDICAL HISTORY & AUTHORISATION FORM**

**Senior Players**

Full Name:................................................................................................................................................

Address: ........................................................................... Town.................................................

Date of Birth: ............................................................................ Phone...............................................

Immunised against Hepatitis A or B?............ If yes, which one ................................

Immunised against Tetanus .................. If yes, date last booster ................................

Blood Group .................. Transfusion if required ................................

Suffer from Asthma? .................. If yes, what medication is used: .................................

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Allergic to Penicillin? .................. Any other allergies .............................................

Is currently taking medication ............... If yes, give details .............................................

Any fractures in the last 3 years.......... If yes, give details .............................................

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Any other medical history, give details ....................................................................................

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**HEALTH CARE DETAILS:**

Medicare No: ............................................ Card Holder’s Name...................................................

Pension No:……............................................. Health Care Card No:.................................................

Expiry Date .............................................

Member of Private Health fund? ................... If yes, give details.......................................................

Detail any additional cover - private hospital, dental etc..........................................................................

Do you require Private or Hospital doctor ....................................................................................

If Private, give own Doctor’s Name & Phone No. ....................................................................................

Do you require Private or Public Hospital ....................................................................................

**EMERGENCY CONTACT**:

Full Name ......................................................................................................................................

Address ......................................................................................................................................

Town .......................................................................................................................................

Phone: (Home).................................(Work)..................................(Mobile)...............................

Relationship ...............................................

**INDEMNITY:**

*This is to certify that I ..............................................................................................hereby authorise the Officials of the Maryborough & District Hockey Association Inc. to obtain on my behalf, any medical, dental or any other assistance as may be deemed necessary for my health and well being, whilst a member of the Maryborough Representative hockey team. I authorise the administering of anaesthetic if this is deemed to be necessary by the attending medical officer, and I guarantee that I will meet any costs incurred.*

***I indemnify all relevant M.D.H.A. Officials whilst in the course of carrying out their duties.***

*Signature ................................................................................... Date .......................................*