Maryborough & District Hockey Assn Inc

**Medical History and Authorisation Form – Junior Players**

**Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Christian Names** |  |
| **DOB** |  | **Phone No.** |  |
| **Address** |  |
| **Parent Names** |  | **Contact No.** |  |
| **Emergency Contact Person** |  | **Phone No.** |  |
| **Address** |  | **Relationship** |  |

**Medical Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Immunised against Hepatistis A or B | **YES / NO** | If yes, which one |  |
| Asthmatic | **YES / NO** | Medication |  |
| Allergies | **YES / NO** | Details |  |
| Blood Transfusion | **YES / NO** | Blood Group |  |
| Heart Problems | **YES / NO** | Respiratory Problems | **YES / NO** |
| Epilepsy | **YES / NO** | Phobias | **YES / NO** |
| Recent Operations | **YES / NO** | Details |  |
| Fractures in the past 3 years | **YES / NO** | Details |  |
| Currently taking medications | **YES / NO** | Details |  |
| Last tetanus Injection Date |  |  |  |
| Permission for Paracetamol to be administered (Parent to supply) | **YES / NO** | Dosage |  |

**Health Care Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Medicare No. |  | Card Holders Name |  |
| Pension Card No. |  | Health Care Card No |  |
| Private Health Fund |  | Details |  |
| Private or Hospital Doctor |  | Private or Public Hospital |  |
| Current Doctor |  | Phone Number |  |

**INDEMNITY:**

*This is to certify that I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Guardian) 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 the health and wellbeing of my son/daughter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ whilst a team 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 MDHA Officials whilst in the course of carrying out their duties.***

*Signature of Parent / Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*