IPSWICH HOCKEY ASSOCIATION INC.

Established 1931

A.B.N. 54 159 436 239

MEDICAL FORM

PLAYER'S NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____ **MEDICARE NO:** _____

TELEPHONE NO: Home: _____ Mobile: _____

PRIVATE HEALTH COVER: YES / NO

DETAILS IF "YES": _____

_____

IF INJURY OCCURS DO YOU WISH TO BE TREATED BY:

PRIVATE DOCTOR: YES / NO

IF "YES": DOCTOR'S NAME: _____

ADDRESS: _____

PHONE NO: _____

HOSPITAL PREFERENCE: PUBLIC / PRIVATE

IF PRIVATE: PREFERRED PRIVATE HOSPITAL _____

Parent / Guardian / Emergency Contacts		
Name:	*Name:*	*Name:*
Relationship:	*Relationship:*	*Relationship:*
Address:	*Address:*	*Address:*
Home Phone:	*Home Phone:*	*Home Phone:*
Work Phone:	*Work Phone:*	*Work Phone:*
Mobile:	*Mobile:*	*Mobile:*
Fax:	*Fax:*	*Fax:*
E mail:	*E mail:*	*E mail:*

Please turn over.....

CURRENT ILLNESS, CONDITIONS OR INJURIES (IF ANY): _____

_____

CURRENT MEDICATION: _____

_____

KNOWN ALLERGIES (IF ANY): _____

_____

DATE LAST TETANUS INJECTION: _____

HEPATITAS "B" IMMUNISATION: YES / NO

I DO/DO NOT GIVE PERMISSION FOR PANADOL TO BE ADMINISTERED.

I authorise office bearers and officials of Ipswich Hockey Association Inc. (I.H.A. Inc.) to take such steps as they consider appropriate to care for my health in the event of sickness or injury whilst I am at the I.H.A. Inc. grounds, travelling officially with the I.H.A. Inc., or representing I.H.A. Inc. at another hockey centre.

I hereby authorise the calling of an ambulance when necessary. I acknowledge that, in emergency situations, treatment may not be able to be organised with the Doctor and Hospital of my choice.

For females, I understand that if I continue to play while I am pregnant, I do so at my own risk.

I undertake to inform I.H.A. Inc. immediately should any of the details provided on this form change.

SIGNATURE: _____

If under 18, Parent/Guardian to sign **AND** please complete the following details:

NAME: _____

RELATIONSHIP TO PLAYER: _____

YOUR ADDRESS: _____

_____