

CITIES HOCKEY CLUB INC.
JUNIOR PLAYER MEDICAL RECORD AND AUTHORISATION.

To be completed by Parent/Guardian and given to the Association Secretary.

1. PLAYER DETAILS:

NAME:

DATE OF BIRTH:

ADDRESS:

EMAIL ADDRESS:.....

HOME TELEPHONE NUMBER:

FATHER'S/MOTHER'S NAME:

BUSINESS ADDRESS:

BUSINESS TELEPHONE NUMBER:

The personal details requested are to enable contact to be made with a player's parents in the event of an emergency, and are strictly confidential.

2. MEDICAL CONDITION:

Please indicate below any known medical conditions which could be aggravated, or have any effect, by the above-named player's involvement in hockey. Wherever the response below is "YES", please describe the nature of the problem or provide a letter from your doctor.

MEDICAL CONDITIONS	RESPONSE	ADDITIONAL COMMENTS
Allergies	YES / NO	
Blood Pressure	YES / NO	
Heart Problems	YES / NO	
Respiratory Problems (other than asthma)	YES / NO	
Asthma - If yes, name of medication.	YES / NO	
Epilepsy	YES / NO	
Any Other Condition		
Date of last Tetanus injection		

3. MEDICAL PRACTITIONER:

Name of family Doctor:

Address:

Telephone Number:

4. INSURANCE:

Health Insurance Fund and Membership Number:

If necessary, would you prefer private or public medical/hospital?

Medicare Number

5. MEDIA RELEASE:

Authorization.....