CONFIDENTIAL HEALTH/ EMERGENCY INFORMATION

NSWCIS Team …….

Name:_____ DOB:____/____/____ Gender: M/ F
First Last (circle)

Address:_____

A. Medical History: Check the ones that apply to your child and describe under the comment section.

	Asthma		**Colour Blindness**		**Aspergers**
	Anaphylaxis		**Hearing Impairment**		**Anxiety/Panic Attacks**
	Bee Sting Allergy		**Vision Impairment**		**Travel sickness**
	Other Allergies		**Intellectual Impairment**		**Other namely:-**
	Diabetes		**Cerebral Palsy**		
	Seizures		**Autism**		

Comments: (e.g. anaphylaxis triggers…. Epi-Pen carried? Asthma - Does your son/daughter carry spare puffer?….other specific allergies …..etc… concerns)

B. MEDICATION: (Include any medication which will be required while playing for NSWCIS.)

NAME	USED TO TREAT	TAKEN WHEN/FREQUENCY	DOES YOUR SON/DAUGHTER SELF ADMINISTER?

C. PAST RELEVANT HISTORY List any past operations, injuries, major illnesses, or hospitalisations relevant to participation in this NSWCIS team

_____

_____

D. SPECIAL DIETARY REQUIREMENTS

_____

_____

E. PARENTS **(Please print)** _____ _____

(Mother) (Father)

Mobile Phone: _____ _____

Home Phone: _____ _____

Work Phone: _____ _____

IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

Name: _____ Relationship to son/daughter _____

Mobile phone:_____ Home phone:_____ Work Phone _____

Permission for Emergency Medical Treatment:

In the event of an emergency (medical or natural disaster) during a NSWCIS event and I/we cannot be contacted, I give my permission for the NSWCIS staff member in charge of medical care to give and/or authorise emergency medical treatment for my son/daughter. I also give my permission to transport my child to a medical treatment centre if needed.

Parent signature: _____Date: _____

Medicare Number _____

Please return this form to the Manager of the NSWCIS Team

Manager……

Contact Details ……..

Please return form by ……