# MEDICAL FORM

## SECTION 1 - COMPETITOR'S DETAILS

Surname : _____ First Name: _____ Student No: _____

University and Campus (eg GU, or GUGC): _____ Age: _____ Sex: _____

Medicare No: _____ Ambulance Subscriber No: _____

Private Health Care Provider: _____ Provider No: _____

Event: _____ Sport: _____

## SECTION 2 - EMERGENCY CONTACT DETAILS

Surname: _____ First Name: _____Relationship: _____

Address: _____

Post Code: _____ Telephone (wk): _____ Telephone (a/h): _____

## SECTION 3 – MEDICAL HISTORY

Please specify any known allergies (eg penicillin, other drugs, foods, plants, animals). Also give details describing seriousness and nature of reaction and necessary treatment.

Please list all medication you are currently taking: _____

_____

Please indicate by circling the appropriate answer if you suffer from or have recently suffered (2 years or less) any of the following conditions.

| | | | |
|---|---|---|---|
| **1.** | Any heart or stroke conditions | **Yes** | **No** |
| **2.** | High blood pressure | **Yes** | **No** |
| **3.** | Pain or tightness in the chest | **Yes** | **No** |
| 4. | Asthma | **Yes** | **No** |
| **5.** | Difficulty in breathing or chronic cough | **Yes** | **No** |
| **6.** | Stomach or duodenal ulcer | **Yes** | **No** |
| **7.** | Liver or kidney condition | **Yes** | **No** |
| **8.** | Diabetes | **Yes** | **No** |
| **9.** | Hernia | **Yes** | **No** |
| **10.** | Epilepsy or fits | **Yes** | **No** |
| **11.** | Fainting attacks | **Yes** | **No** |
| **12.** | Back problems | **Yes** | **No** |

If Yes to any of the above please provide further information:

_____

_____

Have any family members (including grandparents, parents, siblings) had a heart condition prior to age 60? **Yes** **No**
Details: _____

Have you ever had any injury, illness, back or joint condition that may be aggravated by vigorous exercise? **Yes** **No**
Details: _____

Are you pregnant? **Yes** **No**
Details: _____

Do you have any other medical condition that should be made known? **Yes** **No**
Details: _____

Have you had any surgery or injuries in the last six (6) months? **Yes** **No**
Details: _____

Your personal information will only be used in accordance with the objects of AUS for the purpose of providing medical treatment where required. Your details will be held at your University and forwarded to the medical center of each event at which you are a participant. You will be able to access your personal information through AUS upon reasonable notice. If the requested information is not provided you will not be able to receive membership services.

Signed: _____ Witnessed by: _____ Date: _____

Signature of Guardian/ Parent required if under 18years of age: _____ Date: _____