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| **Personal Details** – Please Print: | | | |
| **Surname:** |  | **Given Name:** |  |
| **Address:** |  | | |
| **Suburb:** |  | **Postcode:** |  |
| **Date of Birth:** |  | **Email:** |  |
| **Home Telephone:** |  | **Mobile:** |  |

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| **HEALTH STATEMENT** | | | |
| If you suffers ANY chronic or recurrent ailment, allergy or physical defect, it should be disclosed in order that provision may be made for your welfare. | | | |
| **A** | Do you suffer from any disability? | | YES/NO |
| **B** | Do you suffer from Diabetes, Asthma or Epilepsy? | | YES/NO |
| **C** | Do you have known allergies to drugs, food or other? | | YES/NO |
| **D** | Will you be taking any medication? | | YES/NO |
| **E** | Do you have special food requirements for medical/religious reasons? | | YES/NO |
| **F** | Do you have any other medical condition? | | YES/NO |
| **G** | Your Medicare Number: | | |
| **H** | Are you in a Private Health Fund? | | YES/NO |
| Name of Fund: | | Membership Number: | |
| **I** | Do you have ambulance cover? | | YES/NO |
| **J** | Do you agree to have your photograph published | | YES/NO |
| **K** | Please list TWO persons who may be contacted in case of emergency: | |  |

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| --- | --- | --- | --- |
| **Person 1:** | | **Person 2:** | |
| **Name:** |  | **Name:** |  |
| **Address:** |  | **Address:** |  |
|  | |  | |
| **Phone:** |  | **Phone:** |  |

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| *Note: If any answer is* ***YES*** *from A to F, please give details on the back of this form. You may need to discuss management strategies with the Coach and Manager* | | |
| I hereby consent to participating in Sydney East Hockey Association Representative fixtures. In the event of any accident or illness, I authorise the obtaining on my behalf such medical assistance as my child may require. I also consent to my being admitted to hospital if deemed necessary in the event that I am unable to consent. I undertake to pay medical fees and or costs of drugs and or costs of transport when seeking medical assistance, which may be incurred while under medical care. | | |
| **Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
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**Details of medical condition(s)/medication(s):**

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