**Gippsland Swimming**

**Interdistrict Team Medical Form**

*(To be handed to the Team Manager on the Bus)*

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Doctor**

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Member Number** \_\_\_\_\_\_\_\_\_\_ **Expires** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Ambulance Subscription** YES/NO

|  |  |  |
| --- | --- | --- |
| Medical Condition | Circle | Further information or instruction (please attach additional information if space here is insufficient |
| Travel Sickness | Yes/No |  |
| Asthma | Yes/No |  |
| Fainting/dizzy spells | Yes/No |  |
| Ear Disorder | Yes/No |  |
| Allergies | Yes/No |  |
| Food Intolerance or dietary needs | Yes/No |  |
| Other |  |  |

In the event of illness or accident I authorize the obtaining on my behalf of such medical assistance as my child may require. I accept all operations, blood transfusions and or anesthetic risks involved and the responsibility for payment of my expenses including ambulance costs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**(Signature of Parent)** **(Date)**

Medications normally dispensed by parents for the above conditions should be given to an adult team manager before boarding the bus with detailed instructions for use.

\*\*If you wish the team manager to give panadol to your child if needed in the event of headache, please sign below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **(Date)**

**(Signature of Parent)**