MEDICAL FORM

SECTION 1 - COMPETITOR'S DETAILS

Surname: ________________ First Name: _______________________ Student No: ____________________

Campus (eg Fts Nich or Werribee): ___________________________ Age: _________ Sex: ____________

Medicare No: ____________________________ Ambulance Subscriber No: _______________________

Private Health Care Provider: ________________________ Provider No: __________________________________

Event: **Cross Campus** 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:

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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: ___________