



CHERRYBROOK SENIOR & LITTLE ATHLETICS CLUB INC.

JUNIOR MEDICAL FORM

	Athlete 1	Athlete 2	Athlete 3
Name			
Date of Birth			
Male or Female			
Medical Conditions (if any) - Does your child suffer from: <i>(answer "Yes" or "No" to each question for each child)</i>			
Epilepsy?			
Diabetes?			
Asthma or other respiratory disorder?			
Allergies?			
Migraines or severe headaches?			
Fainting, dizzy spells or sudden loss of consciousness?			
Other relevant medical details, ie injury/operation			
Date of last tetanus Injection			

Medicare Number:

Parent/Caregiver's Name: _____ *(pls print)*

Address: _____

Emergency Contact Number: _____

Do you give permission for the organisers to seek emergency medical treatment if required? (Circle one) YES NO

Conditions (if any): _____

Parent/Carer's Signature: _____ **Date:** _____