

MEDICAL FORM – North Coast Regional Softball Academy



Name: Mr/Mrs/Ms/Miss

Address:.....

Date of Birth:

Phone: (h) (w) (m)

	Date/Additional information
Date last tetanus injection:	Yes/No
Heart Problems	Yes/No
Respiratory Problems	Yes/No
Allergies	Yes/No
Recent Illness	Yes/No
Drugs/Medications required	Yes/No
Drug Reactions (e.g; penicillin allergy)	Yes/No
Blood Pressure	Yes/No
Phobias:	Yes/No
Diabetes:	Yes/No
Epilepsy	Yes/No
Fainting/Dizzy spells	Yes/No
Dietary Recommendations	Yes/No
Behavioral concerns	Yes/No

Doctor's Name/Address/Contact Details: _____

Phone: _____

Medicare No: _____ Expiry Date: _____

Private Medical Insurance: YES / NO

Fund: _____ Member No: _____

Emergency Contact: _____

Phone (h) _____ (w) _____ (m) _____

In the event of an accident or illness I authorise the North Coast Regional Softball Academy (NCRSA) to seek medical attention and agree to pay all medical expenses incurred on behalf of the above player. I further authorise qualified practitioners to administer anaesthetic if the need arises.

Players Signature: _____ Date: _____

Parent's/Guardian Signature: _____ Date: _____
(If player is under 18 years of age)