

Softball SA Inc.

MEDICAL & PREVIOUS INJURY NOTIFICATION FORM

Personal Details:			
Surname:		Given Names:	
Address:			
			P/Code:.....
Contacts:	(phone – home)		(phone – work)
	(mobile)		Email:
	(parent – work)		(parent – mobile)
Date of Birth:			Age in Years:
Height:			Weight:
Blood Group:			

Emergency Contact:			
Surname:		Given Name:	
Contacts:	(phone – home)		(phone – work)
	(mobile)		Relationship:

Health Care Details:			
Medicare No.		Private Health Fund:	
		Priv. Health Fund No.	
Private Doctor:			
Address:			P/Code:.....
Contacts:	(phone)		(mobile)
	(mobile)		Can doctor be contacted at all times?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
Private Dentist:			
Address:			P/Code:.....
Contacts:	(phone)		(mobile)
	(mobile)		Can dentist be contacted in an emergency
			Yes <input type="checkbox"/> No <input type="checkbox"/>

Medical History:			
Do you have/have you experienced any of the following conditions -			
Glandular Fever <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Hepatitis A <input type="checkbox"/>	Hepatitis B <input type="checkbox"/>
Heart Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Heart Murmur <input type="checkbox"/>	Asthma <input type="checkbox"/>
Bronchitis <input type="checkbox"/>	Concussion <input type="checkbox"/>	Migraine <input type="checkbox"/>	
Current Medical Problems: (please list) >			
Current Medication (incl. supplements): (include dosage) >	1.		2.
	3.		4.
Known Allergies: >			
Vaccinations:	Hepatitis: Yes <input type="checkbox"/> No <input type="checkbox"/>	Tetanus: Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If so, when	If so, when	

Do you wear?		
Mouthguard <input type="checkbox"/> >	At Training <input type="checkbox"/>	At Competition <input type="checkbox"/>
Contact Lens <input type="checkbox"/> >	Soft Lens <input type="checkbox"/>	Hard Lens <input type="checkbox"/>
Orthotics <input type="checkbox"/>	Special Protective Equip. <input type="checkbox"/>	Glasses <input type="checkbox"/>

