Health Statement

H1
V2015 07 06

Member Details

Current Year			
Date of Birth		**Membership Number**	

Surname		**Given Name(s)**			
Address					
Suburb		**State**		**Post Code**	
Home Phone		**Mobile Phone**			

Existing Conditions

Provisions for the member's welfare will be made according to the information supplied in this section.
Please tick (✓) boxes and answer fully. Include other documentation as required.

Does the member suffer any of the following?			
	Yes	**Not Known**	**Details**
1. Allergy - Drug	☐	☐	
2. Allergy - Food	☐	☐	
If 'Yes' to food allergy, please include Dietary requirements overleaf.			
3. Allergy – Insect	☐	☐	
4. Asthma	☐	☐	
5. Diabetes	☐	☐	
6. Epilepsy	☐	☐	
7. Heart Condition	☐	☐	
8. Migraine	☐	☐	
9. Sleepwalking	☐	☐	
10. Intellectual Disability	☐	☐	
11. Physical Disability	☐	☐	
12. Other	☐	☐	

Does the member take any medication, tablets, prescription drugs, or use any form of aid?	**Yes** ☐	**No** ☐
Does the member wear or carry a Medic Alert bracelet, charm or card?	**Yes** ☐	**No** ☐
Does the member have any special dietary requirements for medical, religious, or other reasons?	**Yes** ☐	**No** ☐

If YES to any of the above, please provide details in the appropriate area on page 2 of this document.

Has the member been immunised for Tetanus in the past 5 years?	**Yes** ☐	**No** ☐
If no, is permission given for the member to be given a Tetanus injection should the need arise?	**Yes** ☐	**No** ☐

Health Fund Details (Hospitals sometimes require the following information)

Medicare Number		**Expiry Date**		**Ambulance Cover**	
Health Fund (name)				**Health Fund Number**	

Additional Information

Medical Conditions – Drug Requirements

Dietary / Special Food Requirements

Other Information

In the event that medical assistance is required in relation to the above listed medical / health condition, please provide a clear action plan for Leaders to follow.		
Medical Condition		
Action To Be Taken		
Medical Practitioner's Advice		
Medical Practitioner's Contact Details		
Action Plan Attached	**Yes** ☐	**No** ☐
Date of Action Plan		

Emergency Contact Information

Emergency Contact Details (First)	
Name	
Phone	
Relationship to Child	

Emergency Contact Details (Second)	
Name	
Phone	
Relationship to Child	

Parent / Guardian

Signed		**Date**	
Printed Name			
Relationship to Child (Parent / Guardian / Care-giver)			

I agree to provide details to the Leader should any health issues change during the year.

Printed Name of Applicant (if over 18 years)			
Signature of Applicant		**Date**	

Printed Name of Parent / Guardian (if Applicant is under 18 years)			
Signature of Parent / Guardian		**Date**	
Relationship to Applicant (Parent / Guardian / Care-giver)			