MEDICAL / HEALTH INFORMATION FORM

Players Name _____

Player Details

1. Does your child suffer from any of the following :

Diabetes Yes / No Allergy to bee stings Yes / No Asthma Yes / No

Migraines Yes / No Rashes (on feet etc) Yes / No Epilepsy Yes / No

Travel Sickness Yes / No Other (please specify)_____

If **YES** to any of the above, please indicate treatment necessary:

_____

_____

2. Is your child allergic to any food, medicine or drugs? Yes / No

If **YES** what food / medicine / drugs? Does your child have medicine or a treatment plan in case of accidental consumption. Please describe symptoms.

_____

_____

3. Is your child currently on any medicine? Yes / No

If **YES** please supply details.

_____

_____

4. Is there any other information concerning your child that may assist us? (vegetarian, sleepwalker, cultural practices)
Please Specify;_____

_____

5. Do you consent to the Manager providing your child with any of the following?

Panadol Yes / No Arnica cream or tablets Yes / No

It is understood that the management staff will try to the best of their ability to consult parents, prior to players receiving medical treatment, however in an emergency; I agree that my child will be able to receive any required medical treatment while representing Tauranga City Basketball. I understand any medical costs not covered by ACC will be paid by me.

Consenting Parent / Guardian Name _____

Date: ___/___/___

Consenting Parent / Guardian Signature _____

Contact Phone Numbers: Mobile _____ Home_____ Work_____