PLAYER MEDICAL FORM 2024

Please complete and return to info@phantomsvolleyball.com.au

Name: _____ **D.O.B:** _____

Emergency Contact Name: _____ **Relationship to Player:** _____

Emergency Contact Ph #: _____ **Emergency Contact Email:** _____

Name of Family Doctor: _____ **Ph # of Family Doctor:** _____

		YES	NO
Medicare Number:	**Ambulance Victoria Cover:**		
Private Heakth Cover:	**Health Fund:**		
	Member #:		

Please name any medical or other condition which youself/your child suffers from which the club needs to be aware of:

If asthma is a condition, does the player have a puffer, and what medication is in your puffer, what is the recommended dose for a mild and for a severe attack:

	YES
You agree to ensure that the appropriate asthma medication is brought with the player and provided to coaches prior to all training, games and club activities, otherwise the player will be unable to participate:	

Please list any previous sports injuries, approximate dates, and whether or not it is still a problem.:

Does the player suffer with any allergy to any medication such as (select all that apply)

Ibuprofen		Aspirin		Latex	
Penicillins		Non-penicillins		Antibiotics	
Other non steroidal anti inflammatory		Other			

Paracetamol (i.e. Panadol) is generally kept in First Aid Kits. Do you consent for you/your child being offered the recommended dosage of paracetamol if the coach/manager considers it appropriate?

Yes		No	

Does the player suffer with any other allergies such as (select all that apply)

Nuts (any)		Eggs		Fish	
Shellfish		Wheat		Gluten	
Soy		Cows milk		Lactose intolerance	
Other					

If yes, please provide details including emergency medicines such as an Autoinjector (epinephrine) & application

If an auto-injector is required please confirm that you will provide two devices to accompany the player at each training session, match and team participation activity, (if the devices are not provided participantion will not be allowed and you will be asked to collect your child)

Yes | Not applicable

Do you have a family history of cardiac conditions, heart disease or stroke?

Yes | No

If yes please provide details:

Have you ever (to your knowledge) had a concussion/concussions?

Yes | No

If you have had a concussion or concussions, please list the date(s) and circumstance(s) as accurately as possible.

Please list any other medications, prescription or non-prescription, that the player takes regularly, that would be relevant for the ckub to be aware of:

Please share any other details you feel are relevant:

Do you consent to have this information shared with the coaches, and if necessary, on-field medical personnel, Paramedics or other first responders, or hospital staff?

Yes | No (if no then the player will not be able to participate)

CONSENT TO MEDICAL ATTENTION

Where the club is unable to contact me, or it is otherwise impractical to contact me, I authorise the club to:
(a) consent to my child receiving such medical or surgical attention as may be necessary by a medical practitioner or, (b) administer such first aid as the coach/manager in charge may judge to be reasonably

Signed player or Parent/Guardian: