Water Polo
SOUTH AUSTRALIA

PLAYER'S

MEDICAL INFORMATION FORM

This form is intended to assist the coach / manager in case of any medical emergency involving a squad member. **All information is held in confidence.**

NAME:		D.O.B.:	
State Training Squad:			

Parent's / Guardian's Name :					
Address:					
Email Address:					
Home Ph:		Work Ph:		Mobile:	

Medicare No:	
Private Health Fund:	
Membership No:	
Ambulance Fund:	
(I am aware that I am responsible for ambulance costs)	
Emergency Contact numbers:	
Name:	
Telephone number/s:	
Relationship to team member	
Name:	
Telephone number/s:	
Relationship to team member	

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Prior to leaving, all medications must be cleared with your Coach /Manager as to whether they are approved by ASADA and not on the banned drugs list. Player's may be tested at any WPA sanctioned event / competition. A medical certificate may be required for some prescription drugs. You can check your substances and print receipts to bring on https://checksubstances.asada.gov.au/

Please tick if the above team member suffers any of the following:

Asthma		Fainting		Allergies	
High Blood Pressure		Nose Bleeds		Diabetics	
Heart Condition		Eczema		Drug Allergies	
Hayfever		Epilepsy		Sight/Hearing Problem	
Headaches		Fits or Blackouts		Other Medical Condition/s	

If YES to any of the above, please give details below or add an attachment:

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For Epipen users and severe asthmatics, please attach details of the action plan.

Last Tetanus shot: ____

Do you consent to the team member receiving Panadol, Dymadon or Nurofen for temporary pain relief, high temperature or fever?

YES / NO ____

Do you consent to the team member receiving blood transfusion for medical reasons if required?

YES / NO ____

Is there any other information that you believe may help to provide the best possible care for the player?

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Consent to medical attention:

In the case of an emergency, I authorise the Coach / Manager, where it is impracticable or unable to communicate with me, to arrange for the player to receive such medical or surgical treatment as may be deemed necessary.

I also undertake to pay costs which may be incurred for medical attention, ambulance transport and drugs while the player is travelling as a member of the team.

______________________	______________________	____________
Player's Signature	**Print Name**	**Date**
______________________	______________________	____________
Parent/Guardian's Signature **(if player under 18 yrs)**	**Print Name**	**Date**

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