

GOLF AUSTRALIA MEDICAL FORM.

95 COVENTRY STREET, SOUTH MELBOURNE 3205

PLEASE RETURN MEDICAL FORM AT VOLUNTEER REGISTRATION.

GIVEN NAME(S) _____ SURNAME _____

ADDRESS (if supplied mark **As Registered**) _____

_____ P/CODE _____ DATE OF BIRTH _____

EMERGENCY CONTACT PERSON DURING EVENT _____

RELATIONSHIP _____

CONTACT PERSON'S PHONE (H) _____ (B) _____ (M) _____

REGULAR DOCTOR OR CLINIC _____ PHONE _____

LIST ALL MEDICATION BEING TAKEN AND DOSAGE: _____

DO YOU SUFFER FROM: **ASTHMA** Yes / No **EPILEPSY** Yes / No **DIABETES** Yes / No

HEART CONDITION Yes / No (If so, please specify treatment on reverse)

List and provide details of all **MEDICAL CONDITIONS, RECENT OR PRE-EXISTING INJURIES, MAJOR SURGICAL PROCEDURES, OR ANY CONDITION THAT COULD AFFECT YOU AT THE 2008 MFS WOMEN'S AUSTRALIAN OPEN.**

LIST ALL ALLERGIES, LEVEL OF REACTION AND USUAL TREATMENT _____

I authorise Golf Australia's nominated representative to disclose all my medical information to a third party in the event I require medical treatment.

I acknowledge that I am responsible for all costs incurred on my behalf for all medical treatment and emergency transport if required.

The above details are an accurate indication of my present medical status.

SIGNATURE _____ DATE _____

IF YOU ARE UNDER 18 AT PRESENT, A PARENT / GUARDIAN MUST COMPLETE

I accept the above conditions on behalf of the applicant

SIGNATURE OF PARENT / GUARDIAN _____ DATE _____