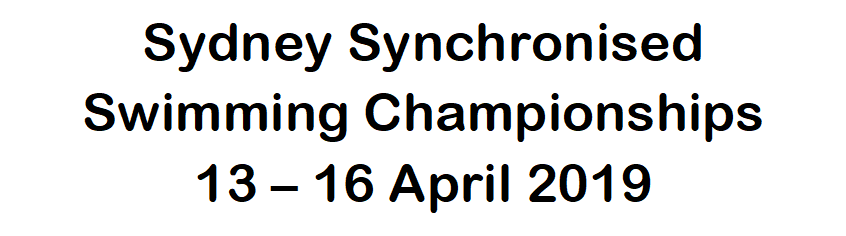
|  |  |
| --- | --- |
| **COMPETITOR’S NAME** |  |
| **COMPETITOR’S MOBILE NUMBER** |  |



**EMERGENCY CONTACT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME OF EMERGENCY CONTACT** | **RELATIONSHIP TO COMPETITOR** | **PHONE NUMBER(S)** | **COMMENTS** |
|  |  |  |  |
|  |  |  |  |

**MEDICAL INSURANCE DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICARE NUMBER** |  | | **REFERENCE** |  | **EXPIRY DATE** |  |
| **PRIVATE HEALTH FUND** |  | **MEMBERSHIP NUMBER** | |  | | |
| **DOCTOR’S NAME** |  | **DOCTOR’S PHONE NO.** | |  | | |

**Please note any special dietary requirements for this Competitor:**

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| --- |
|  |
|  |
|  |
|  |

**Please note any allergies this Competitor has:**

|  |  |  |  |
| --- | --- | --- | --- |
| **ALLERGIC TO** | **REACTION SYMPTOMS** | **TREATMENT** | **COMMENTS** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Please note any medication this Competitor takes:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REASON FOR MEDICATION** | **MEDICATION TAKEN** | **DOSAGE AMOUNT AND FREQUENCY** | **SELF MEDICATE or ASSISTANCE REQUIRED** | **COMMENTS** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Should feel unwell, are you happy for the Coach or House Mother to administer pain relief in the form of Paracetamol or Ibuprofen if appropriate? |  |  |

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**Please note any other medical related information for this Competitor that the Coach and House Mothers need to be aware of (e.g. Contact Lenses, Dental Prosthesis, etc.):**

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**PLEASE ADD ANY GENERAL COMMENTS OR NOTES APPLICABLE TO THE COMPETITOR FOR THEIR COACHES AND HOUSE MOTHER:**

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| --- |
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|  |  |  |
| --- | --- | --- |
| **COMPETITOR SIGNATURE** | |  |
| **PARENT OR GUARDIAN SIGNATURE (IF UNDER 18)** | |  |
| **DATE** |  | |