



# PLAYER MEDICAL ADVICE FORM

FAMILY NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

## MEDICAL HISTORY:

1. DO YOU SUFFER FROM ANY MEDICAL ILLNESSES? NO YES  
(Particularly Diabetes, Asthma, Epilepsy)

Details: \_\_\_\_\_

2. ARE YOU CURRENTLY ON ANY MEDICATION? NO YES

Details: \_\_\_\_\_

3. DO YOU HAVE ANY ALLERGIES? NO YES  
(Bee Stings, Penicillin, etc)

Details: \_\_\_\_\_

4. DO YOU HAVE ANY EXISTING INJURIES? NO YES

Details: \_\_\_\_\_

5. DO YOU HAVE ANY OTHER MEDICAL PROBLEMS? NO YES

Details: \_\_\_\_\_

## PLAYER / PARENT / GUARDIAN EMERGENCY CONTACT

#1 CONTACT NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PH: \_\_\_\_\_ MOBILE: \_\_\_\_\_

#2 CONTACT NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PH: \_\_\_\_\_ MOBILE: \_\_\_\_\_

FAMILY DOCTORS NAME: \_\_\_\_\_ PH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MEDICARE # \_\_\_\_\_ PRIVATE HEALTH: YES NO \_\_\_\_\_

AMBULANCE COVER: YES NO \_\_\_\_\_

I \_\_\_\_\_ (Print Name)

agree to pay all medical expenses and or ambulance expenses obtained on my behalf (or my above named child's behalf) due to any emergency illness or injury as deemed necessary by AVFC in my absence and exempt AVFC and/or its associated body from all liability and costs.

Signed \_\_\_\_\_ Date: \_\_\_\_\_