

RIDER'S MEDICAL PROFILE - PERSONAL RECORD

SURNAME: GIVEN NAMES:
 ADDRESS:
 POST CODE: PHONES: (07) home (07) work
 SEX: DATE OF BIRTH: AGE: HEIGHT: WEIGHT:Kg
 BLOOD GROUP: Do you object to transfusions:

EMERGENCY CONTACT

SURNAME: GIVEN NAMES:
 PHONES: (07) home (07) work mobile
 Relationship:

HEALTH CARE DETAILS

MEDICARE NO: Private Health Insurance Yes / No Which:
 DOCTOR: PHONE: (07)
 DR's ADDRESS:
 Can the Doctor be contacted at all times? Yes / No
 DENTIST: PHONE: (07)
 Dentist's Address:
 Can the Dentist be contacted at all times? Yes / No

CURRENT HISTORY

Current Medical Problems:
 Regular medications including supplements, stating name and dosage
 Allergies: Injuries:
 Is your tetanum booster current? Yes / No. Date of last booster:

Have you had...	Yes/No	Do You Wear..	Yes/No	Have you sustained...
Epilepsy		Glasses		A fracture in the last 3 years? Yes No
Hepatitis A		Contact Lenses		Where?
Hepatitis B		Protective		A dislocation? Yes No
Diabetes		Equipment		Where?
Heart Problems		Mouthguard		Do you suffer from.....
Asthma/bronchitis		Braces		Recurring pain in any joints? Yes No
Hernia				Which Joint?
Concussion				

Have you ever been treated for head or spinal injury? Yes () No () Give details:

To the best of my knowledge, all information contain on this sheet is correct.

Signed: Date:
(Rider or Parent/Guardian)