# MEDICAL / HEALTH
## INFORMATION FORM

PLAYERS NAME _____

### PLAYER DETAILS

1. Does your child suffer from any of the following

Diabetes Yes ☐ No ☐ Allergy to bee stings Yes ☐ No ☐ Asthma Yes ☐ No ☐

Migraines Yes ☐ No ☐ Rashes (on feet etc) Yes ☐ No ☐ Epilepsy Yes ☐ No ☐

Travel Sickness Yes ☐ No ☐ Other (please specify) _____

If YES to any of the above, please indicate treatment necessary:

_____

_____

Is your child allergic to any food, medicine or drugs? Yes ☐ No ☐

If **YES** what food / medicine / drugs? Does your child have medicine or a treatment plan in case of accidental consumption. Please describe symptoms.

_____

_____

Is your child currently on any medicine? Yes ☐ No ☐

If **YES** please supply details.

_____

_____

Is there any other information concerning your child that may assist us?
(vegetarian, sleepwalker, cultural practices) Please Specify;

_____

_____

Do you consent to the Manager providing your child with any of the following?

Panadol Yes ☐ No ☐ Arnica cream or tablets Yes ☐ No ☐

It is understood that the management staff will try to the best of their ability to consult parents, prior to players receiving medical treatment, however in an emergency; I agree that my child will be able to receive any required medical treatment while representing Tauranga City Basketball. I understand any medical costs not covered by ACC will be paid by me.

**Consenting Parent / Guardian Name** _____

**Consenting Parent / Guardian Signature** _____ **Date:** _____

**Contact Phone Numbers:**

**Mobile** _____ **Home** _____ **Work** _____