

# HCFC Medical Information and Consent Form

A copy of this form will be held in confidence by your child's Coach/ Team Manager.

Players Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ M or F (Circle)

Address \_\_\_\_\_

Suburb \_\_\_\_\_ Post Code \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Mobile Ph \_\_\_\_\_ Home Ph \_\_\_\_\_

Name and Address of Doctor \_\_\_\_\_

Phone No \_\_\_\_\_

Medicare No \_\_\_\_\_ Member of Ambulance Service Y or N

Private Health Fund \_\_\_\_\_ Member No \_\_\_\_\_

Please advise of you child's Medical Condition or Allergies:

If your child has a treatment plan please advise on reverse of this form.

Are you aware of any physical or psychological limitations of your child? If so please give details  
\_\_\_\_\_

Is there any other information which you believe may help us to provide the best possible care?  
\_\_\_\_\_

**Consent to medical attention.** In the case of my child requiring medical treatment or in the case of a medical emergency, I consent a qualified person to provide first aid treatment as outlined in the attached emergency treatment plan and I further authorise HCFC, where I am uncontactable, to arrange for him/her to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay any costs which may be incurred for the medical treatment, ambulance transport and drugs

Signed \_\_\_\_\_ Parent/ Carer

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY** ORIGINAL  COPY

Date of Incident \_\_\_\_\_ Medical Treatment Given By: \_\_\_\_\_

Date of Incident \_\_\_\_\_ Medical Treatment Given By: \_\_\_\_\_

**DETAILS TO BE PROVIDED ON REVERSE OF THIS FORM**