Bacchus Marsh Pony Club Inc.

MEDICAL HISTORY FORM

The information you provide on this Medical History Form will be kept by your Pony Club in a secure place and used only in the event of an emergency.

Personal Details

First Name: ..... Last Name: .....

Sex: ..... Vehicle/Float Reg No.: .....

Date of Birth: ..... Age: .....

Height: ..... Weight: .....

Blood Group: .....

Do you object to blood transfusions? ☐ Yes ☐ No

Have you been immunised for Tetanus ☐ Yes ☐ No If Yes, Date: .....

Emergency Contacts

First Name ..... Last Name: .....

Phone (h) ..... Phone (w): .....

Relationship: .....

First Name ..... Last Name: .....

Phone (h) ..... Phone (w): .....

Relationship: .....

Medicare No.: .....

Do you have Ambulance Cover? ☐ Yes ☐ No Ambulance No.: .....

*If no ambulance cover is held you are strongly advised to arrange such cover as if an ambulance needs to be called it will be at your expense.

Do you have Private Health Cover? ☐ Yes ☐ No Fund: .....

GP: ..... Phone: .....

Address: .....

Suburb: ..... Postcode: .....

Can your Doctor be contacted at all times? ☐ Yes ☐ No

Dentist: ..... Phone: .....

Address:.....

Suburb: ..... Postcode: .....

Can your Dentist be contacted at all times? ☐ Yes ☐ No

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Are you affected by any of the following conditions?

Epilepsy	☐ Yes	☐ No	Dyslexia	☐ Yes	☐ No
Hepatitis (any form)	☐ Yes	☐ No	Eating problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No
Blood Pressure problems	☐ Yes	☐ No	Migraine	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Nerve Disorder	☐ Yes	☐ No
Asthma/Bronchitis	☐ Yes	☐ No	Skin Complaints	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No	Visual or hearing complaints	☐ Yes	☐ No
Hernia	☐ Yes	☐ No	Other (please specify)	☐ Yes	☐ No
Attention Deficit Disorder	☐ Yes	☐ No	.....		
Allergic reactions	☐ Yes	☐ No	.....		
Bladder/Bowel complaints	☐ Yes	☐ No	.....		
Diabetes	☐ Yes	☐ No			

If Yes to any of the above, please give details of condition(s) and special requirements: .....

.....

.....

.....

.....

Regular medications including supplements, stating name and dosage: .....

.....

.....

.....

Sports injuries (please list any injury, which is current/recurring or requires surgery): .....

.....

.....

.....

Do you wear?

Glasses:	☐ Yes	☐ No
Contact Lenses:	☐ Yes	☐ No
If Yes:	☐ Soft	☐ Hard

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In the past have you ever sustained?

A fracture ☐ Yes ☐ No

If Yes, when & body part:.....

.....

A dislocation ☐ Yes ☐ No

If Yes, when & body part:.....

.....

Have you or do you suffer from:

Recurring joint pain ☐ Yes ☐ No

If Yes, when & body part:.....

.....

Back/Neck pain ☐ Yes ☐ No

If Yes, when:.....

.....

Have you ever been treated for a:

Concussion ☐ Yes ☐ No

If Yes, when:.....

.....

Head injury ☐ Yes ☐ No

If Yes, when:.....

.....

Neck injury ☐ Yes ☐ No

If Yes, when:.....

.....

Spinal injury ☐ Yes ☐ No

If Yes, when:.....

.....

I certify that the information given on this form is to be best of my knowledge a true account of my current physical condition.

Rider Name: ..... Signature: ..... Date: .....

Parent/Guardian: ..... Signature: ..... Date: .....

Medical Release

Member over 18years

If emergency medical care is required for myself and if I, or an accompanying spouse or relative, am not able to convey permission in a timely manner, then the undersigned authorised authorises appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

Rider Name: ..... Signature: ..... Date: .....

Member under 18years

If emergency medical care is required for my child.....

and if permission is not available in a timely manner, then the undersigned authorised authorises appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

Parent/Guardian: ..... Signature: ..... Date: .....