



Medical Form

Personal Details

Surname _____ Given Names _____

Address _____ Postcode _____

Home Phone _____ Date of Birth ____/____/____

Mother's Name _____ Occupation _____

Work Phone _____ Mobile _____

Father's Name _____ Occupation _____

Work Phone _____ Mobile _____

Emergency Contact Details

Surname _____ Given Names _____

Home Phone _____ Work Phone _____

Mobile _____ Relationship to child _____

Health Care Details

Blood Group _____ Do you object to transfusions YES / NO

Medicare Number _____ Ambulance Cover YES / NO

Private Health Insurance YES / NO Fund/Cover _____

Private Doctor _____ Telephone _____

Address _____ Postcode _____

Can the doctor be contacted at all times YES / NO

If urgent attention is required and neither parents or the alternative number given can't be reached, I give consent for my child to be treated by a medical practitioner as arranged by Rebound Sport Aerobics.

Signed _____ Parent / Guardian Date _____

