



Consent, health and information sheet 2011

ACKNOWLEDGEMENT AND CONSENT

I authorise the Trott Park Fencing Club Incorporated to obtain emergency medical / dental / hospital / ambulance assistance deemed necessary, should an accident or sudden illness occur and agree to pay all medical and dental expenses incurred on behalf of the person named in "Your details". I further legally authorise qualified medical practitioners to administer an anaesthetic or to carry out necessary surgical procedures if such an eventuality occurs.

I give permission for images (photographic or electronic reproductions) of the person named in "Your details" to be used for the purpose of promoting the sport of fencing and the Trott Park Fencing Club Incorporated without further consent. I understand that any subsequent objection to the use of any images for the purpose described above, must be advised in writing to the Secretary, Trott Park Fencing Club Incorporated.

I have checked all the information provided and confirm it is accurate to the best of my knowledge.

Name _____ Signature _____
Parent/Guardian if under 18 years

Date ____/____/____

YOUR DETAILS

Club member's full name

Address

Postcode _____ **Date of birth** ____/____/____

Phone numbers

_____ (Home) _____ (Work)

_____ (Mobile)

Email address

Trott Park Fencing Club Inc.

Meets

Gymnasium
Sheidow Park
Primary School

Enter from

Alkira Road
Sheidow Park 5158

Wednesday evenings

7 pm – 9 pm

Coach

Jenny Cassidy
National Police Checked

Nationally accredited
NCAS Level 2
Foil, Epée, Sabre

EMERGENCY CONTACT PERSON

Name and relationship

Phone numbers

_____ (Home) _____ (Work)

_____ (Mobile)

HEALTH INFORMATION

Do you have any allergy / medical condition / health problem? **YES / NO**

If you have answered "YES", please provide details of the allergy / medical condition / health problem

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Are you aware of any medical emergency which could occur? **YES / NO**

If answered "YES", please provide details:

| Precautions to avoid emergency | How to recognise emergency | Emergency treatment to be administered |
|--------------------------------|----------------------------|--|
| | | |

MEDICATION

Do you take any prescribed medication (including inhalers)? **YES / NO**

If you have answered "YES", please give details and if required, ensure the medication is available at training / competitions

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MEDICARE / PRIVATE HEALTH FUND DETAILS

Medicare card number

If you are a member of any private medical benefit fund, please provide details:

| Fund name tables | Membership number | Benefit |
|------------------|-------------------|---------|
| | | |

If you are covered by an ambulance subscription, please provide details: _____
