



**FUN STAR CALISTHENIC ACADEMY**

**MEDICAL FORM**

**CHILDS FULL NAME:**.....

**MEDICARE NUMBER:**.....

**ARE YOU A MEMBER OF A PRIVATE HEALTH FUND:**.....

**IF YES, PLEASE GIVE DETAILS:**.....

**DOES THE CHILD HAVE AMBULANCE COVER:**.....

<b>MEDICAL CONDITION</b>	<b>YES/NO</b>	<b>DETAILS</b>
<b>HEART CONDITION</b>		
<b>RESPIRATORY CONDITION (INCL ASTHMA)</b>		
<b>ALLERGIES</b>		
<b>EPILEPSY/FAINTING/DIZZINESS</b>		
<b>DIABETES</b>		
<b>DRUG REACTIONS/ALLERGIES</b>		
<b>OTHER RELEVANT INFORMATION</b>		
<b>WILL YOUR CHILD REQUIRE MEDICATION DURING CLASS?</b>		
<b>IF YES, CAN IT BE SELF ADMINSTERED?</b>		
<b>DETAILS OF MEDICATION</b>		
<b>DOSAGE</b>		
<b>WHEN DOES IT NEED TO BE TAKEN?</b>		

PLEASE PROVIDE AN ALTERNATIVE CONTACT PERSON SHOULD YOU BE UNCONTACTABLE IN THE EVENT OF ILLNESS OR AN ACCIDENT

NAME:.....

ADDRESS:.....

CONTACT NUMBER:.....

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE, THE INFORMATION CONTAINED WITHIN THIS FORM IS TRUE AND ACCURATE.

I AGREE TO INFORM FUN STAR CALISTHENIC ACADEMY INC. IN THE EVENT THAT ANY OF THIS INFORMATION CHANGES AND OF ANY PERTINENT INJURIES/ILLNESSES THAT ARE DIAGNOSED DURING THE YEAR.

I UNDERSTAND THAT AT THE EARLIEST POSSIBLE TIME, I WILL BE NOTIFIED OF ANY ILLNESS OR ACCIDENT INVOLVING MY CHILD AND THAT CARE WILL BE GIVEN IN ACCORDANCE WITH THE DETAILS GIVEN ABOVE. SHOULD IT BE NECESSARY FOR MY CHILD TO HAVE MEDICAL TREATMENT WHILST IN THE CARE OF FUN STAR CALISTHENIC ACADEMY INC. PERSONNEL, I GIVE THEM PERMISSION TO USE THEIR JUDGEMENT IN OBTAINING THE BEST SERVICE AVAILABLE.

I UNDERSTAND THAT ANY MEDICAL COSTS INCURRED WILL BE MY RESPONSIBILITY.

SIGNED:.....

DATED:...../...../.....