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## Medical Consent and Indemnity

Gymnasts Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M / F  
SURNAME First Name  
(Please Circle) Attending Aerial Silks on: 10<sup>th</sup> & 12<sup>th</sup> January 2012 OR 17<sup>th</sup> & 19<sup>th</sup> January 2012

Address: \_\_\_\_\_

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

Parent/Guardian 1: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

**\*\* PLEASE ENSURE NUMBERS ARE CORRECT AS THEY MAY BE NEEDED IN CASE OF AN EMERGENCY\*\***

1. I, (*parent if under 18*) \_\_\_\_\_, hereby give permission for the Program Coordinator/Coach, to seek medical aid in the event of an accident, injury or illness to the above Aerial Silks Workshop participant.

2. General medical aid, including transport, will be at the discretion of the Program Coordinator/Coach. In addition:

Specific permission, on appropriate medical advice, is given for the following:

- Traumatic injury requiring surgery  Yes  No
- General Anesthesia  Yes  No
- Has your child been vaccinated for  Hep A  Hep B  Tetanus
- Does your child suffer from a condition that could involve hospitalisation (eg. Asthma etc)?  
 Yes  No If Yes, please state: \_\_\_\_\_

● Known Allergies: \_\_\_\_\_

● Medical Problems: \_\_\_\_\_

Medication required (*please include dosage*):

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
(N.B. Medication can only be administered if dosage is clearly labeled by Dr and Pharmacy Pack)

Medicare Number: \_\_\_\_\_

I, We have additional Hospital/ Medical cover  Yes  No

Name of Fund: \_\_\_\_\_

Membership Number: \_\_\_\_\_

Signature: \_\_\_\_\_ (Parent/Guardian)

**Note: Parents will be contacted, if possible, prior to any medical attention being given.**