

Hornsby District Little Athletics Centre Inc.

(Established in 1969)



MEDICAL QUESTIONNAIRE

Athlete's Name	Age group	Rego No.

Does your child suffer from any of the following:	Yes	No	If yes, please specify condition & instructions for treatment, if any:
Epilepsy, Diabetes, Asthma, Allergies, Migraines or Dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	
Any known disability?	<input type="checkbox"/>	<input type="checkbox"/>	
Current or past injuries?	<input type="checkbox"/>	<input type="checkbox"/>	
Any other conditions?	<input type="checkbox"/>	<input type="checkbox"/>	

Additional information:

I give permission to Hornsby District Little Athletics Centre Inc. to seek emergency medical treatment for my child if required.

Name (please print): _____

Signature: _____ Date _____

Telephone contact in case of emergency: _____