

Hornsby District Little Athletics Centre Inc.

(Established in 1969)



Medical Questionnaire

Athlete's Family & Given Names:

New Registration No.:

Medical History

Does your child suffer from any of the following:	If yes, please specify condition & instructions for treatment, if any:
Epilepsy, Diabetes, Asthma, Allergies, Migraines, Dizziness, etc.? <p style="text-align: right;">Yes / No</p>	
Any known disability? <p style="text-align: right;">Yes / No</p>	
Current or past injuries? <p style="text-align: right;">Yes / No</p>	

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

Name (in print)

Signature **Date** / /