PO Box 4332, Darwin NT 0801

Top End Calisthenics Club Inc.

Personal/Medical Information Sheet

This Consent Form is applied to all approved Calisthenics related events i.e.: classes / tuition / fund-raising events / camps / approved outings / competitions / presentations, etc.

Name: _____ **Date of Birth:** _____/_____/_____

Section: Please Circle: Tinies or Future Stars Sub-Juniors Juniors Intermediates Seniors

Is this individual over the age of 18? YES / NO (**Please Circle) If** under 18 years of age a parent / legal guardian is required to complete the remainder of this form.

Emergency Contact Name and Number: _____

Known Allergies: _____ Reaction **To Allergens**: _____

Life Threatening Consequences: YES / NO

Pre-Existing Conditions: Either Present Or Previous (Please Tick)

	Yes	No
Asthma	[ ]	[ ] Please outline Asthma Plan Overleaf.
Balance / Co-ordination Problems	[ ]	[ ] Please Describe:_____
Blood Pressure Problems	[ ]	[ ] Please Describe:_____
Breathing Difficulties	[ ]	[ ] Please Describe:_____
Diabetes	[ ]	[ ] Please Describe:_____
Dizziness / Fainting Spells	[ ]	[ ] Please Describe:_____
Epilepsy / Fits / Seizures	[ ]	[ ] Please Describe:_____
Fears we need to be aware of	[ ]	[ ] Please Describe:_____
Headaches Recurrent, including Migraine	[ ]	[ ] Please Describe:_____
Hearing Difficulties	[ ]	[ ] Please Describe:_____
Hyperventilation	[ ]	[ ] Please Describe:_____
Heart Conditions	[ ]	[ ] Please Describe:_____
Joint / Muscle Problems	[ ]	[ ] Please Describe:_____
Neck / Spine Problems	[ ]	[ ] Please Describe:_____
Numbness Or Loss Of Sensation	[ ]	[ ] Please Describe:_____
Previous Surgery	[ ]	[ ] Please Describe:_____
Problems With Previous Anaesthetics	[ ]	[ ] Please Describe:_____
Sight Problems	[ ]	[ ] Please Describe:_____
Swallowing Difficulties	[ ]	[ ] Please Describe:_____
Any Other Conditions Not Listed Above	[ ]	[ ] Please Describe:_____

_____

Is the above named participant on any relevant medications at present? Not including general antibiotics and medications taken for a very short period of time. YES / NO Please **List**

_____

_____

ASTHMA PLAN (Fill Out Only If Applicable)

Factors That Trigger An Asthma Attack

_____

Presenting Signs / Symptoms Of An Asthma Attack

_____

1st Stage Treatment: _____

(Please Outline 1st Line Medication And Treatment To Be Implemented)

IF NO RESPONSE TO 1ST STAGE TREATMENT, FOLLOW UP WITH THE FOLLOWING:

2nd Stage Treatment: _____

_____

(Please Outline 2nd Line Medication And Treatment To Be Implemented)

IF NO RESPONSE TO 2ND STAGE TREATMENT, FOLLOW UP WITH THE FOLLOWING:

3rd Stage Treatment: _____

_____

(Please Outline 3rd Line Medication And Treatment To Be Implemented)

Outline Names of Medications To Be Used And Dosages Of Medications Below:

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Signature: _____ **Date:** _____/_____/_____.

Relationship To The Above Mentioned, Whom The Asthma Plan Relates To: _____.