Whitsunday Regional Endurance Riders Association Inc.

PARTICIPANTS MEDICAL FORM

Full Name: _____

Date of Birth: _____

Name of Parent/Guardian: _____

Telephone: _____
Mobile *Home* *Work*

Are you in a Medical Insurance Fund? Yes / No

Have you / your child had a tetanus booster in the last 12 months? Yes / No

PLEASE COMPLETE THE FOLLOWING MEDICAL INFORMATION

	Circle One	*Please list any details*
Heart problems	Yes / No	
Respiratory problems	Yes / No	
- Asthma	Yes / No	
- Other	Yes / No	
Allergies	Yes / No	
- Food	Yes / No	
- Drugs	Yes / No	
- Ointments	Yes / No	
- Other	Yes / No	
Sugar diabetes	Yes / No	
Blood pressure	Yes / No	
Recent operations	Yes / No	
Epilepsy	Yes / No	
Recent illness	Yes / No	
Phobias	Yes / No	
Others	Yes / No	

If other medication is required indicate dose and application:

Medical problem Medication Dosage When to be taken

_____

SIGNATURE & DATE: _____
Signature *Date*