



ANNUAL HEALTH STATEMENT

YEAR

MEMBERSHIP NUMBER

MEMBERS DETAILS.

Surname: [] First Name: []

Address: []

Date of Birth: [] Home Phone No: [] Mobile No: []

Provisions for the member's welfare will be made according to the information supplied in this section. Please tick boxes and answer fully. Include other documentation as required.

Does the applicant suffer any of the following?

	YES	Not Known	Details
1. Allergy - Drug			
2. Allergy - Food			If 'YES' to food allergy – Please include with Dietary requirements overleaf
3. Allergy - Insect			
4. Asthma			
5. Diabetes			
6. Epilepsy			
7. Heart Condition			
8. Migraine			
9. Sleepwalking			
10. Intellectual Disability			
11. Physical Disability			
12. Other			

***IF "Yes", please provide full details, including names of drugs and frequency of administration on the reverse of this form.**

Does the member take any medication, tablets, prescription drugs or use any form of aid? <i>Please provide details Page 2 of this form</i>	Yes	No
Does the member wear or carry a Medic Alert bracelet, charm or card? <i>Please provide details Page 2 of this form</i>	Yes	No
Does the member have any special dietary requirements for medical, religious or other reasons? <i>Please provide details Page 2 of this form</i>	Yes	No
Has the member been immunised for Tetanus in the past 5 years? No	Yes	
If Not: Can the member be given a Tetanus injection should the need arise? No	Yes	
Medicare No: []	Health Fund: []	
Ambulance Fund No: []	Health Fund No: []	

I agree to provide details to the Leader should any health issues change during the year.

[]	[]	[]
Signature of Applicant (if over 18 years)	Signature of Parent/Guardian (if applicant under 18 years)	Date



Note: Form A4 are to kept by the Leader in Charge

Additional information:

Medical Conditions – Drug Requirements etc

Dietary/Special Food requirements:

Other Information:
