



# MEDICAL CONSENT FORM

(insert name of organization) .....

Name: ..... Date of Birth: .....

1. Are you required to have medications with you when taking part in sport? Yes/No  
If yes, what kind? .....

2. Have you ever had any of the following?

Asthma Yes/No                      Diabetes Yes/No  
Epilepsy Yes/No                      Heart Complaints Yes/No

3. Do you have any allergies? Yes/No  
If yes, please specify .....

4. Have you had any injuries to the head? Yes/No  
If yes, please specify .....

Were you unconscious? Yes/No  
If yes, for how long? Hours ..... Days .....

5. Do you have any other illness/injuries that may affect participation? Yes/No  
If yes, please specify .....

6. Have you had the following inoculations? Yes/No

Tetanus Yes/No Date: ..... Smallpox Yes/No Date: .....  
BCG Yes/No Date: ..... Hepatitis Yes/No Date: .....  
Polio Yes/No Date: .....

Signed: ..... Date: .....

Print Name: .....

Relationship to team member: .....

(If under 18 years of age, a parent or guardian must sign above. Please state relationship to team member.)

**THIS FORM WILL BE RETAINED IN CONFIDENTIAL FILES AND IS FOR USE IN EMERGENCIES ONLY**