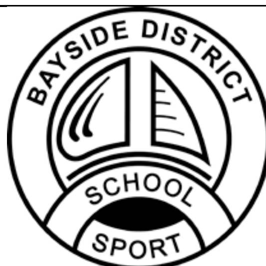
BAYSIDE DISTRICT SCHOOL SPORT		**Bayside District Secretary** Anna Rasmussen Capalaba State College Ph: 3823 9333 Email: arasm34@eq.edu.au

STUDENT DETAILS FORM – BAYSIDE DISTRICT

Player Details			
Surname		Male ☐ Female ☐	
Given Name			
Date of Birth			
Home Address			
		Postcode	
Home Telephone		Mobile Telephone	
Contact Email			

Parent / Guardian / Carer 1			
Surname		Given Name	
Home Address (If different to Player's)			
		Postcode	
Home Telephone		Mobile Telephone	
Contact Email			

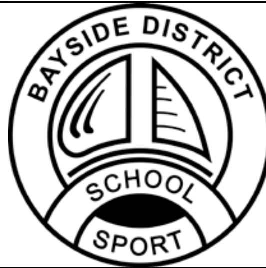
Parent / Guardian / Carer 2			
Surname		Given Name	
Home Address (If different to Player's)			
		Postcode	
Home Telephone		Mobile Telephone	
Contact Email			

Contact Person (When parent / guardian / carer cannot be contacted)			
Surname		Given Name	
Home Address (If different to Player's)			
		Postcode	
Home Telephone		Mobile Telephone	

Any Relevant Family History

Bayside District as an operational unit of the Department of Education, Training and Employment is collecting the information on this form in accordance with the Information Privacy Act 2009 for the purpose of contacting you in regard to your child's participation in a *Bayside District* Event. The information will only be accessed by persons authorised by *Bayside District* ,including appointed team officials. The information provided will not be used or disclosed to any other person or agency unless either you have given permission, it is required by law or in the interests of student health and welfare.

This form to be returned to: ***DISTRICT SPORTS CONVENOR/MANAGER/COACH***

BAYSIDE DISTRICT SCHOOL SPORT		**Bayside District Secretary** Anna Rasmussen Capalaba State College Ph: 3823 9333 Email: arasm34@eq.edu.au

MEDICAL DETAILS FORM – BAYSIDE DISTRICT

Surname		
Given Name		Male ☐ Female ☐

Where a YES or NO response is required please enter that word in the cell rather than a tick or cross.

Immunisation Details (Please complete. List others as appropriate. Enter the words YES or NO rather than ticks.)			
Injection	**Yes**	**No**	**Date of Injection (dd/mm/yy)**
Tetanus	☐	☐	
Hepatitis B	☐	☐	
	☐	☐	

Do you get asthma? Is your asthma, Exercise induced asthma?	Yes ☐ Yes ☐	No ☐ No ☐
If Yes to any of the above, list medication and attach Action Plan.		
Do you suffer from Anaphylactic reactions?	Yes ☐	No ☐
If Yes list medication and attach Action Plan		
Are you currently being treated by a medical practitioner?	Yes ☐	No ☐
If Yes list details. NOTE: Please list any current medication.		
Do you have an injury or condition which is likely to be aggravated by competition? If yes, explain:	Yes ☐	No ☐
I understand that mouth protection is mandatory in rugby league, rugby union, Australian Rules Football, hockey, water polo and handball (European/team). I accept responsibility for the type of mouth protection i/my child will wear whilst playing this sport.	YES	N/A

Medicare Card Number				
Cardholder Name (if not in name of student)				
Private Health Insurance Company Name (if covered)				
Private Health Insurance Membership Number				
Do you have **Personal Accident & Injury Insurance** cover against accident/injury for competitions and associated activities (training, travel, etc.) Your attention is drawn to the fact that Redland District carries no insurance cover against accident or injury during competition and/or associated activities (eg, travel, training)	Yes		No	
Personal Accident & Injury Insurance Company Name				

Please list any other relevant medical history

I hereby authorise the obtaining on my behalf of such medical assistance as my child may require in the event of an accident or illness. I authorise the administration of anaesthetic if this is deemed necessary by the medical officer attending.

Signed: ________________________ ***Dated:*** ______________