

DEE WHY SHOTOKAN KARATE CLUB
Medical history form

Personal details

First name: _____ Last name: _____

Address: _____

Tel: h _____ w _____ mobile _____

Gender: M F (please circle) Date of birth: _____

Email Address: _____

Emergency contact

First name: _____ Last name: _____

Address: _____

Tel: h _____ w _____ mobile _____

Relationship: _____

Health care details

Doctor's name: _____ Tel: _____

Dentist's name: _____ Tel: _____

Medical details

Do you have any allergies? yes / no (please circle)

If yes, please list: _____

Please list any medical conditions that you have (for example, asthma, diabetes, epilepsy):

Please list any regular medications you require (include dosage):

Sports injury details

Please list any current or recurring injuries:

Do you suffer from recurring pain in any joint when engaging in sporting activities?

yes / no (please circle). If yes, please provide details:

Have you ever had a head, neck or spinal injury? yes / no (please circle)

If yes, please provide details:

Is there ANYTHING ELSE that you wish to disclose that may be relevant to your safe participation in the karate classes offered by Dee Why Shotokan Karate Club?

yes / no (please circle). If yes, please provide details:

To the best of my knowledge, all information contained on this form is correct
(if under 18 please have a parent or guardian sign)

Signature: _____

Date: _____

Note: All the medical information contained in this form will be treated as confidential and will only be divulged to a medical professional in the case of an emergency.