PORT MACQUARIE CROQUET CLUB
Member's Medical Record

My Details:

Name .....

Address .....

.....

Phone .....

Mobile .....

Date of birth .....

In an Emergency contact:

Name .....

Mobile .....

Name .....

Mobile .....

I suffer from (tick where appropriate):

- ☐ History of heart disease
- ☐ Pacemaker
- ☐ History of stroke / TIA
- ☐ Diabetes
  - ☐ Insulin dependent
  - ☐ Non-insulin dependent
- ☐ Asthma
- ☐ Epilepsy
- ☐ Metal pins / plates
- ☐ Reaction to anaesthetic
- ☐ Reaction to x-ray contrast (dye)
- ☐ Allergies

.....

.....

My Doctor:

Name .....

Medical Practice .....

Phone .....

Private Health ☐ Yes ☐ No

Blood group .....

Any further relevant medical history you would like to include:

.....

.....

.....

.....

.....

This is a true record of my medical details signed .....

date .....