Bundaberg Bushwalking Club Inc.

MEMBER EMERGENCY CONTACT & MEDICAL INFORMATION

It is recommended that this information is to be carried in a sealed plastic envelope in your First Aid Kit in your pack at all times and is for emergency use only.

It is responsibility of each member to update this information if there is a change in details.

Medical Conditions: .....

.....

Current Medications: .....

.....

Allergies: .....

.....

Blood Type: .....

Do you have current immunisation against Tetanus Y/N

Privacy Statement:

The information contained in this form is for emergency use only and will be used if you are ill or injured whilst participating in a *Bundaberg Bushwalking Club Inc.* activity. The information will only be accessed by the walk leader or their delegate and given to the relevant medical and/or emergency services personnel

I give permission for *Bundaberg Bushwalking Club Inc*. to give first aid to me should the need arise.

Signed: Date:

Please Turn Over

TITLE: ☐Mr ☐Mrs ☐Miss ☐Ms ☐Other: .....

FAMILY NAME:

.....

GIVEN NAMES:

.....

PREVIOUS NAME: (If applicable)

.....

DATE OF BIRTH: .....

SEX / GENDER: ☐Male ☐Female

COUNTRY OF BIRTH: ☐ Australia ☐Other

Please specify: .....

MARITAL STATUS (Please tick one only)

☐ Never Married
☐ Married
☐ Separated
☐ Widowed
☐ De facto
☐ Divorced

RELIGION: .....

LANGUAGE – Main language spoken at home:

☐English ☐Other(please specify) .....

Interpreter Required: ☐Yes ☐No

PERMANENT ADDRESS:

.....

.....

.....

.....

.....

Home Phone No. .....

Work Phone No. .....

Mobile Phone No. .....

USUAL GP / FAMILY DOCTOR

Name: .....

Practice: .....

Address: .....

.....

Phone: .....

Fax: .....

FIRST CONTACT PERSON:

Name: .....

Address: .....

.....

Home Phone No. .....

Work Phone No. .....

Mobile Phone No. .....

Relationship: .....

OTHER CONTACT PERSON:

Name: .....

Address: .....

.....

Home Phone No. .....

Work Phone No. .....

Mobile Phone No. .....

Relationship: .....

MEDICARE No. .....

You are person number ..... on the Medicare Card?

Expiry date of Medicare Card: ...../.....

DVA Card No. .....

☐Gold ☐White ☐Orange

Are you a member of the **Department of Defence**?

☐Yes ☐No

Is this attendance related to a:

☐ **WorkCover Claim**
☐ **Third Party–Motor Vehicle Accident**
☐ **Third Party -Other**

Incident Date: .....

Do you have Private Health Insurance? ☐Yes ☐No

Health Fund: .....

Health Fund Cover: ☐Hospital Only ☐Extras Only

☐Hospital with Extras ☐Hospital with waiting period

☐With exclusions

Health Fund No: .....

HCC/Pension No. .....

Pension Expiry Date: .....

PBS Safety Net ID No. .....