CENTRAL COAST WOODTURNERS CO-OP LTD

~ Member Medical Information Sheet ~

Please note that this information is to be used only in case of an emergency
Where urgent medical help is required. It is designed to aid you in getting the best and quickest help available.

Members Full Name : _____

Address : _____

_____

Date of Birth: / / **Blood Type (if known):** _____ **Religion:** _____

Home Phone Number: _____ **Mobile Number:** _____

Medicare Number: _____ **Position on Card:** _____

Pension Number: _____

Health Fund: _____ **Health Fund Number:** _____

Next of Kin: _____ **Relationship:** _____

Address: _____ **Contact No:** _____

_____

Emergency Contact 2: _____ **Contact No:** _____

Emergency Contact 3: _____ **Contact No:** _____

Family Doctor's Name, Address, Phone Number

_____

_____

_____

_____

_____

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Specialists names, Area of Expertise and Phone Number:

Allergies:

Present Medical Conditions:

Brief Medical History:

Current Medications and Dosage Rates:

Please feel free to include additional pages if there is insufficient space available.

** By signing this form you give permission for this information to be passed on to Ambulance and Hospital Staff if necessary

Signature: _____ **Todays Date**: ____ / ____ / ____

Give this completed form to a Committee Member asap.

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Members Full Name: _____

Additional Medical Information: