NPAQ HEALTH FORM

Medical Details - Please use back of form if space is insufficient

Name: _____ DOB: _____

Pre-existing medical conditions: _____

Previous medical conditions: _____

Prescribed medications: _____

First Vaccination Date Second Vaccination Date Booster Date

COVID Vaccination Manufacturer _____

Emergency Contact During Activity

Full Name: _____

Relationship: _____ Phone / Mobile: _____

Further Medical Details

Do you have any specific instructions in the event of illness or accident (e.g. Allergies)?

enter here : _____

Blood Type: _____ Organ Donor Yes/No: _____

GP's name: _____ Phone: _____ Mobile: _____

Specialist's name: _____ Phone: _____ Mobile: _____

Health Fund: _____ Phone: _____ HF No.: _____

Medicare No: _____ Pensioner No: _____ DVA No: _____

THE ABOVE INFORMATION IS FOR EMERGENCY USE ONLY

Disclaimer and Signature

Please complete this form, sign it, and put IN A SEALED ENVELOPE WITH YOUR NAME ON THE ENVELOPE, **AND KEEP THE ENVELOPE WITH YOU AT ALL TIMES.**

Signed: _____ Date: _____

This Activity will comply with the COVID-19 requirements as set by Queensland Health
see https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/public-health-directions