HOLLAND PARK STATE SCHOOL AMATEUR SWIMMING CLUB
MEDICAL INFORMATION

NAME	**Last:**	**First:**
ADDRESS		
	Suburb:	**Post code:**
PHONE#	**Home:**	**Work:**
MOBILE#		**DOB:**

Please complete the following. This information is kept confidential.

			Further Information
Allergy (eg Bee Sting)	Y	N	
Breathing Disorder (Asthma)	Y	N	
Ear Disorder	Y	N	
Epilepsy	Y	N	
Fainting/Dizziness	Y	N	
Diabetic	Y	N	
Any other relevant information:			

I/We certify that the answers to the above questions are true and that any medical information has not been withheld.

I/We undertake to immediately advise the Holland Park State School Amateur Swimming Club of any change to the information which may occur.

Name of Parent Guardian		
	(First)	(Last)
Signature		
Date		