



# ***MOTORCYCLE SPORTSMEN OF QLD Inc.***

## **RIDER/VOLUNTEER MEDICAL INFORMATION - 2012**

PLEASE PRINT

Each rider/volunteer must complete this form (including sidecar passengers) concerning their medical history. Information obtained will be treated as confidential and will only be available to the Doctor/Health Professionals to use in the event of any injuries or accidents.

***THIS FORM IS MANDATORY***

Name of Rider/Volunteer:

Nickname:

Residential Address:

Phone Home:

Mobile:

Work:

Date of Birth:

Medicare #:

Weight:

Height:

Next of Kin:

Relationship:

Next of Kin Contact Number: (MANDATORY)

Marital Status:

Name of Partner/Spouse:

Children:

Address:

<b>Phone Home:</b>	<b>Mobile:</b>	<b>Work:</b>
<b>Name of General Practitioner:</b>		
<b>Surgery Address:</b>		
<b>Surgery Phone:</b>	<b>Mobile:</b>	<b>A/H:</b>
<b>What is your blood group?</b>		
<b>Do you have false teeth?</b> <b>Caps or crowns? If yes give details:</b>		
<b>Do you smoke?</b> <b>If yes how many per day?</b>		
<b>Have you ever had neck problems?</b> <b>If yes give details:</b>		
<b>Have you ever had back problems?</b> <b>If yes give details:</b>		
<b>Have you ever had broken bones?</b> <b>If yes give details:</b>		
<b>Do you have any allergies?</b>		

**If yes give details: eg penicillin/iodine?**

**When did you last have a tetanus injection?**

**Do you take any prescribed medication or drugs on a regular basis?**

**If yes give details:**

**Do you have any medical conditions or illnesses?**

**If yes give details:**

**Do any complications arise if you are administered a general anaesthetic?**

**If yes give details:**

**Have you ever used steroids (hydrocortisone/prednisone)?**

**If yes give details:**

**When?**

**For how long?**

**Any other relevant or important medical details:**

- 1. I have provided all relevant and important medical details;**
- 2. I agree that the Motorcycle Sportsmen of Qld Inc. and its agents will not be liable for any medical treatment I receive and will not be responsible or liable for the confidentiality of this information once handed to health professionals.**

**Signature:**

**Date:**