Hornsby District
Little Athletics Centre Inc.

(Established in 1970)

MEDICAL QUESTIONNAIRE

Athlete's Name	Age group	Rego No.

Does your child suffer from any of the following:	Yes	No	If yes, please specify condition & instructions for treatment, if any:
Epilepsy, Diabetes, Asthma, Allergies, Migraines or Dizziness?	☐	☐	
Any known disability?	☐	☐	
Current or past injuries?	☐	☐	
Any other conditions?	☐	☐	

Additional information:

I give permission to Hornsby District Little Athletics Centre Inc. to seek emergency medical treatment for my child if required.

Name (please print): ____

Signature: ______________________________ **Date** __________________

Telephone contact in case of emergency: ______________________________