



## Adult Emergency Personal Details (over 18 years)

The details below are very important in the event of an accident or personal injury.

Please complete correctly and fully. Each field is optional, however, this information provides a valuable medical background for any medical unit responding. By providing these details you consent to the Trip Leader providing this document to the medical team.

This Emergency Personal Details form should be placed in a sealed envelope with your name on the front. Details need to be completed for **EACH** person in the vehicle or participating in the event or training session. We suggest that you complete the form/s at home before leaving and place them in envelopes with your name on the front. The details for a trip: need to be completed in triplicate (3 copies) – one copy remains in your vehicle, one copy to the trip leader (TL) and one copy to the Tail End Charlie (TEC). For an event or training session one should be given to the instructor or co-ordinator.

All envelopes will be returned at the conclusion of the trip/event/session- please ensure you ask for their return from your Trip Leader/Co-ordinator or Instructor. For convenience, children have been included on this form. You only need to complete their details once. Each adult should have their own form completed.

### Date form Completed:

Name	
Pajero 4WD Club Membership Number	
Date of Birth	
Address	
Home Phone	
Mobile	

### General Practitioner Information:

Dr's Name	
Address	
Contact No:	
Medicare Number:	
Valid to:	
Ambulance Membership Number:	
Private Health Insurance	Fund Name:                      Membership Number

Do you wish to use your Private Health Membership in the event of an emergency?

Yes

☐

No

☐

### Personal Medical Information

Please list any current medical conditions or illnesses.

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Are you allergic to, or intolerant of any medications, food, plasters or latex? If yes, please list substance and reaction below.

Substance	Reaction

Please list any medication or drugs you are currently taking. (Include: Prescribed medications, anticoagulants, pills, puffers, eye or nasal drops, natural remedies, recreational drugs)

Name of Medication (Prescribed and Other)	Dose	How often

Please answer 'Yes' or 'No' if you suffer from any of the following:

	Yes	No	Details
High Blood Pressure			
Heart Surgery /Stent /Angina /Chest pain/ Heart attack / Pacemaker inserted/ Atrial Fibrillation / Heart Palpatations			
Asthma/Emphysema/Lung Problems			
Problems with high blood sugar ( diabetes)			Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet <input type="checkbox"/>
Bleeding disorder or treatment for excessive bleeding			
Have you had a stroke before?			
Kidney problems?			

Blood Group (if known)	
Do you consent to receiving a Blood Transfusion or Blood products in the event of an emergency?	
YES <input type="checkbox"/>	NO <input type="checkbox"/>

If in the event you are not able to make a decision about your medical treatment, who would you like us to contact to advocate on your behalf?

On the trip with you:

Name	
Contact Number	
Relationship	

Not on the trip/event/session (preferably 2 persons):

	Contact 1	Contact 2
Name		
Address		
Contact Number		
Relationship		

I understand that this health information will be provided to the responding medical personal to assist in providing a relevant medical history to facilitate medical management in the event of an emergency or injury.

Signed:	
Date :	



## Child Emergency Personal Details Form (under 18 years of age)

Name	
Date of Birth	

### Personal Medical Information

Please list any current medical conditions or illnesses.

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Is your child allergic to, or intolerant of any medications, food, plasters or latex? If yes, please list substance and reaction below.

Substance	Reaction

Please list any medication or drugs your child is currently taking. (Include: Prescribed medications, anticoagulants, pills, puffers, eye or nasal drops, natural remedies, recreational drugs)

Name of Medication (Prescribed and Other)	Dose	How often

Blood Group (if known)	
Do you consent to your child receiving a Blood Transfusion or Blood products in the event of an emergency?	
YES <input type="checkbox"/>	NO <input type="checkbox"/>

Please complete this form for each dependant/child in your vehicle.