



## CAIRNS YOUTH EMPOWERED TOWARD INDEPENDENCE MEDICAL INFORMATION FORM

<b>EMERGENCY CONTACT DETAILS:</b>			
Contact Person:			
Relationship to Applicant:			
Phone (Home):	Other:		
<b>MEDICAL DETAILS</b>			
Date of birth:	Gender:		
Height:	Weight:		
Do you suffer from any of the following diseases? (please circle)			
Arthritis	Epilepsy	Bleeding condition	
Asthma	Kidney Disease	Heart disease	
Diabetes	Blood Pressure	Other (please state) _____	
Do you suffer from any medical condition requiring medication or injection? If so please indicate.			
Do you have any food allergies? (provide details)			
Do you have a history of heart problems? (provide details)			
Do you have any disabilities? (provide details)			
Do you have any fears or phobias? (provide details)			
Have you had a tetanus toxin injection? (provide circle)			
Within 2 yrs	Within 10 yrs	More than 10 yrs	Never
Do you wear contact lenses?		Do you wear dentures?	
Do you have any special dietary requirements? (provide details)			
Can you swim?			
Medicare No:		Private Health Fund:	
Signature:		Date:	
Signature of Parent/Guardian (if under 18 yrs)		Date:	