**2020 Variety-SHINE CLIENT EMERGENCY MEDICAL**

**PERSONAL DETAILS**

**Client Surname**

**Given Names**

Street: ……………………………………………………………………………………………………….……

Suburb: ………………………………………………………………………….Post Code: ………………

**Address**

**Date of Birth / / Sex: (M/F)**

**Emergency Details 1**

**Contact Name Relationship**

**Mobile No**

**Emergency Details 2**

**Contact Name Relationship**

**Mobile No**

**Identify Health / Medical Risks**

**Please indicate if your child has had or now has any of the following:**

**Allergies Asthma Chicken Pox**

**Seizures Ear Infections Headaches**

**Epilepsy Sinus Other**

**You must provide us with an Emergency Medical Plan for Allergies, Seizures / Epilepsy.**

**You must give Dr Parsons any medications that should be administered during the program.**

**Medicare No**

**Ambulance Fund Subscriber**

**YES**

**NO**