BWHA U16 Medical & Consent Form 2025

Please complete this form without logging in.

All players and officials representing BWHA at a tournament must complete a Medical Form prior to the tournament they are attending. This information will remain private and confidential and be retained in our system until the end of the Calendar year (December 31 2025).

If you have further supporting documents or information that needs to be provided, please upload via the tab provided. Please speak to your team manager if you need to discuss further.

Contact email address

1. (Required) Legal Disclaimer and Consent Agreement (Tick all that apply)

I, as the participant (or the parent/guardian of the participant named on this medical form, if the participant is under 18 years of age), give my consent for participation in the above tour under the supervision of BWHA-authorised personnel. I acknowledge that all BWHA rules and regulations will apply at all times. Supervision will be provided in a manner that ensures the safety and well-being of all participants. Any failure to comply with the required standards of conduct may result in the participant being sent home at their own or their parent/guardian's expense. I further understand and agree that the authorised personnel in charge of the tour have the authority to act on my behalf in the event of an emergency, including seeking medical or surgical treatment if necessary. I accept responsibility for reimbursing BWHA for any medical expenses incurred in such circumstances. I understand that, if emergency medical treatment is required, the authorised personnel will make every effort to contact me as soon as possible. Additionally, I authorise qualified medical practitioners to administer anesthesia, transfusions, or other necessary medical procedures if required. I acknowledge that all reasonable precautions will be taken by BWHA and its authorised personnel to ensure the safety and well-being of participants. However, I agree not to hold BWHA or its authorised personnel responsible for any unforeseen incidents beyond their reasonable control.

☐ I consent to the terms and conditions outlined above

2. Who is completing this form? (Please tick ONE option)

☐ Myself

☐ Parent/Guardian

Parent/Guardian

3. First Name (Parent/Guardian)

4. Last Name (Parent/Guardian)

5. Team (Please tick ONE option)

☐ Brisbane 1

☐ Brisbane 2

☐ Brisbane 3

☐ Brisbane 4

☐ Brisbane 5

6. Team 6 & 7 (Please tick ONE option)

☐ Brisbane 6

☐ Brisbane 7

7. (Required) Date of Birth (Player)

____/____/_____

Emergency Contact

8. First Name (Emergency Contact)

9. Last Name (Emergency Contact)

10. Phone Number (Emergency Contact)

(If mobile number, please add 61 in front of your number and leave off the 0)

11. (Required) Medicare Number (including reference number)

12. (Required) Medicare Cardholder Name

Immunisation Records

13. (Required) Tetanus (Date of last booster)

____/____/_____

14. Hepatitis B Vaccination (Please tick ONE option)

☐ Yes

☐ No

15. Meningococcal C Vaccination (Please tick ONE option)

☐ Yes

☐ No

Medication

16. (Required) Please give full details of any prescribed medication being taken (including dosage, frequency and any doctors instructions) if medical plan in place please submit separately below

Medical History

Do you suffer from any of the following? (Please provide relevant information in Medical Management if yes)

17. (Required) Asthma (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

18. (Required) Other Respiratory Problems (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

19. (Required) Drug Allergies (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

20. (Required) Diabetes (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

21. (Required) Epilepsy (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

22. (Required) Heart Condition (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

23. (Required) Blood Pressure (Please tick ONE option)

If yes, please specify details in Medical Management

☐ Yes

☐ No

24. Other - Please specify

Other Medical Allergies (food allergies are listed later)

25. (Required) Recent Injuries

26. (Required) Do you snore? (Please tick ONE option)

☐ Yes

☐ No

27. Please give full details of any problems either medical or physical which would limit your full participation in any activity

Food Allergies

28. (Required) Do you have any food allergies (Tick the single best answer)

☐ Yes

☐ No

29. Medical Management

30. Food Allergy List

Please list any food allergies team officials need to be aware of (eg Dairy, Wheat, Vegan etc)

31. Medical Management Plan

Medical Management Plan Submission (if applicable)