



Parelli Centre Australia

Confidential Medical History & Emergency Contact 2018

Phone: +61 2 4630 9443 • Email: info@parelli.com.au

Mailing and Street Address :50 Lisa Road, Wilton, NSW 2571

Web: www.parelli.com.au

Please complete, scan and then email to info@parelli.com.au

Name: _____ Local Contact # (while in Wilton) _____

Course: _____ Female Male Date of Birth _____ Age _____

Medicare Policy # _____ Phone: _____

Who to Contact in Case of Emergency

Name: _____ Phone: _____

Relationship to you: _____ Mobile Phone: _____

Has your Doctor placed any restrictions on your activities? Yes No

If Yes Please Explain: _____

Are There Any Reasons Why You Should Not Participate in Any Event or Class Offered By Parelli? Yes No

If Yes Please List: _____

Current Medications: (name/dose/frequency) _____

Do You Have Any Allergies? Yes No

If Yes Please List: _____

Do You Have or Have Had Any of The Following in the Last 12 months? (if yes please explain)

	Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Joint Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Neck/Back Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Need Special Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Severe Pain	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart/Cardiac Condition	<input type="checkbox"/>	<input type="checkbox"/>
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>			

Signature _____

Date _____

*This form will be held on file for you, and will be used if required for any courses you attend at the Wilton Centre through 2018. Please advise our staff of any changes to this form throughout the year.