Windeward Bound Trust

Sail Trainee Registration Form & Confidential GP Health Questionnaire

SECTION 1 Confidential GP Health Questionnaire
(This section to be completed by a licensed GP with access to your medical history)

Given Name	Surname	Preferred Name (If different)
Name on Medicare Card & Number (Australian only)		
Private Health Cover Fund & Number (if applicable)		

DOB	Gender Female/Male/Other	Blood Type:	T Shirt Size S, M, L, XL	Height (cm) Weight (kg)

Please Tick all that apply

Does the applicant suffer from any illness or disability? ❑
(This includes hearing, sight, and mental health/learning difficulties)
Is the applicant currently receiving any medication or other treatment? ❑

Has the applicant suffered from any of the following, either currently or in the past (Please tick all that apply)?

Asthma (Circle: Slight, Mild, Extreme)	❑	Giddiness	❑
Hayfever	❑	Severe headaches, migraines	❑
Reaction to specific foods, drugs or injections (Specify below)	❑	Sleepwalking, sleeping difficulties	❑
Fainting attacks or blackouts	❑	Tendency to bleed or bruise easily	❑
Epilepsy, fits, or convulsions	❑	Diabetes	❑
Any communicable disease including HIV or any form of Hepatitis A, B, or C	❑	Travel sickness – sea sickness	❑

If you have ticked ANY boxes above, please give a detailed explanation here (including all medication, dosage and frequency):

It is my opinion that the applicant ***IS / *IS NOT** medically fit to handle the rigours of a multi-day sea voyage ***Please circle**

Medical Officer's Name:	Signature:	Date:
Name of Practice (*Please use Practice Stamp if possible):*		
Practice Address:		
Phone:	Email Address:	
How long have you known this patient?		

SECTION 2 Medical Release and Emergency Contact Details
(*To be completed by Applicant or Parent/Guardian if applicant under 18 years)*

In the event of an accident or serious illness, I hereby give permission to the Commanding Officer of the Windeward Bound to seek medical attention on my behalf.

Name:	Signature:	Date:
Next of Kin *(NOK)*: *(Name of person to be contacted in the event treatment in required)*		NOK Relationship to applicant:
NOK Email Address:		NOK Mobile Number:
NOK Address:		
Dietary requirements and/or allergies and intolerances. E.g. Vegetarian, gluten, peanuts or N/A?		

SECTION 3 Applicant Information
To be completed by Applicant or Parent/Guardian if applicant under 18 years)

Postal Address:	
Email Address:	Phone Number:
Signature:	**Date**