Karate-Do Goju-Kai Australia

VICTORIAN DIVISION

AFFILIATED TO: INTERNATIONAL KARATE-DO GOJU-KAI ASSOCIATION (I.K.G.A.)

PRE-PARTICIPATION QUESTIONNAIRE

PERSONAL DETAILS

Surname

Given Name(s)

Address

Suburb / Town / City | State | Postcode

Home Telephone — Area Code | Number

Business Telephone — Area Code | Number

Sex M F

Date of Birth / /

Mobile

EMERGENCY CONTACT

Surname

Given Name(s)

Home Telephone — Area Code | Number

Business Telephone — Area Code | Number

Relationship — Spouse/Parent

Mobile

HEALTH CARE DETAILS

Medicare Number

Private Health Insurance Yes No — Fund

Private Doctor — Name

Telephone — Area Code | Doctor

Can Doctor be contacted at all times? Yes No

If yes, after hours contact — Area Code | AH: Doctor

Private Dentist — Name

Telephone — Area Code | Dentist

Can Dentist be contacted in emergency? Yes No

If yes, after hours contact — Area Code | AH: Dentist

OTHER COMMITMENTS

Do you participate in any other sports? Yes No

If yes, please complete table below for each sport

Sport	Number of sessions per week	Approximate length of sessions

Do you attend other group/activities scouts, youth groups, etc)? Yes No

If yes, please complete table below for each group / activity

Group / Activity	Number of sessions per week	Approximate length of sessions

Please list any other activities that you have a regular commitment to (e.g. part time work, music lessons, etc).

Activity	Number of sessions per week	Approximate length of sessions

PRE-PARTICIPATION QUESTIONNAIRE

MEDICAL DETAILS

Blood Group

Do you object to transfusions? Yes No

Have you received medical clearance from your doctor recently? Yes No

Do you take any regular medications? Yes No

Do you participate in any other sports? Yes No

If YES, list regular medications

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HAVE YOU HAD...

Epilepsy Yes No

Hepatitis A Yes No

Hepatitis B Yes No

Diabetes Yes No

Heart Problems Yes No

Heart Murmur Yes No

Hernia Yes No

VISION

Do you wear:

Glasses Yes No

Hard contact lenses Yes No

Soft contact lenses Yes No

VACCINATIONS

Have you been vaccinated against:

Hepatitis A Yes No

Hepatitis B Yes No

Tetanus Yes No

Other Yes No

If OTHER, list vaccination

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HIV (optional) Yes No

Status

CONCUSSION

Have you ever had '**concussion**'?

Yes No

How many times?

Give approximate dates

/ /

/ /

/ /

/ /

/ /

TEETH

Do you wear a mouthguard?

Yes No

If YES, specify type

Do you wear your mouthguard?

At Training Yes No

At Competition Yes No

ASTHMA

Do you suffer from asthma?

Yes No

Do you take medication for asthma?

Yes No

If YES, specify medication

ALLERGIES

Are you allergic to:

Tape Yes No

Ice Yes No

Medications Yes No

Specify allergy medications

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List any other allergies you have:

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Do you wear protective head gear?

Yes No

If YES, specify type

INJURY DETAILS

Have you been injured in the past 12 months

Yes No

If YES, specify injury

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Are there any past injuries still effecting your performance (e.g. pain, stiffness)?

Yes No

If YES, specify

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Do you wear protective equipment?

Yes No

If YES, specify equipment type

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Do you require specific taping/ padding for a previous injury?

Yes No

If YES, specify

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Have you sustained a fracture in the last 3 years?

Yes No

If YES, specify type

Have you sustained a dislocation in the last 3 years?

Yes No

If YES, specify type

Have you ever had a head, neck or spinal injury?

Yes No

If YES, specify type

To the best of my knowledge, all information contained on this sheet is correct.
(If under 18 please have parent or legal guardian sign)

Signature

Date / /