Shed West Community Mens Shed Inc.

PO Box 391, Kenmore, Qld. 4069

MEDICAL DISCLOSURE FORM

Please Note: (1) Completion and submission of this Form is voluntary. (2) All information about you stored by Shed West is available to you (and can be amended by you at any time) on your request to the Secretary.

Full Name: _____

Date of Birth _____

Address: _____ P/Code: _____

Medical Information

Note: Provision of any element of your medical information is voluntary. ie. You can leave the answer to any question below blank if you want.

1 **Blood Group** ……. **2** **Are you an Organ Donor? (Yes or No)?** …..... (If you are an Organ Donor then please state in Section 6 below whether you have excluded any organs or tissues for donation and, if so, list which ones).

3 **Surgical Implants (all you have)** ……

4 **Medical Condition(s)**: That you want confidentially recorded by Shed West. (Please include all **Allergies and Intolerances,** if any)

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5 **Medication(s)**: List all that you take medium-term and long-term. ……..

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6 **Other Additional Medical Information**: (if relevant). ……..

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Authorisation :

I authorise the Secretary or another approved representative of Shed West to make this information available to appropriate medical personnel in the event of me being the subject of a medical emergency.

Member's Signature: _____ **Date:** _____

OFFICE USE ONLY Date form received: Officer who received it:
