MEMBERS RENEWAL / UPDATE DETAILS

ALL INFORMATION SUPPLIED WILL BE STRICTLY CONFIDENTIAL

BARAMBAH BOWHUNTERS MEMBERSHIP	***PAID -***	***DATE:***

MEMBER INFORMATION

(NAME)		**BBHFA #**
(RESIDENTIAL ADDRESS)		
(POSTAL ADDRESS)		
(EMAIL ADDRESS)		
(PHONE NUMBER)	**(DATE OF BIRTH)**	

(NAME)	**(DATE OF BIRTH)**	**BBHFA #**
(NAME)	**(DATE OF BIRTH)**	**BBHFA #**
(NAME)	**(DATE OF BIRTH)**	**BBHFA #**
(NAME)	**(DATE OF BIRTH)**	**BBHFA #**
(NAME)	**(DATE OF BIRTH)**	**BBHFA #**

BBFA-MEM-001

MEDICAL INFORMATION FORM

NAME: (SURNAME)	**(GIVEN NAMES)**	
HOME ADDRESS:		
DATE OF BIRTH:	**MALE or FEMALE**	**BLOOD GROUP (IF KNOWN):**
PHONE: (HOME)	**(MOBILE)**	**(WORK)**

NAME OF PREFERRED CONTACT

NAME: (SURNAME)	**(GIVEN NAMES)**	
HOME ADDRESS:		
DATE OF BIRTH:	**RELATIONSHIP:**	
PHONE: (HOME)	**(MOBILE)**	**(WORK)**

HEALTH DETAILS

A	**HEART PROBLEMS**	**YES**	**NO**	**I**	**DEAFNESS**	**YES**	**NO**
B	**RESPIRATORY PROBLEM**	**YES**	**NO**	**J**	**PHYSICAL DISABILITIES**	**YES**	**NO**
C	**ALLERGIES**	**YES**	**NO**	**K**	**RECENT ILLNESS**	**YES**	**NO**
D	**TRAVEL SICKNESS**	**YES**	**NO**	**L**	**RECENT OPERATIONS**	**YES**	**NO**
E	**BLOOD PRESSURE**	**YES**	**NO**	**M**	**DRUGS REQUIRED**	**YES**	**NO**
F	**EPILEPSY**	**YES**	**NO**	**N**	**DRUG REACTIONS**	**YES**	**NO**
G	**DIABETES**	**YES**	**NO**	**O**	**OTHER**		
H	**DYSLEXIA**	**YES**	**NO**				

MEDICAL PRACTITIONER

DOCTOR'S NAME:	**PHONE:**

I DECLARE THE PARTICULARS HERE TO BE TRUE AND CORRECT. I SHALL NOTIFY THE PEOPLE REQUIRED OF ANY CHANGE IN THIS INFORMATION, OR FORFEIT THE RIGHT OF CLAIM.

SIGNATURE: ..... DATE: .....

PARENT / GUARDIAN'S SIGNATURE IF UNDER 18: ..... DATE: .....

IF THERE ARE MULTIPLE PEOPLE FOR RENEWAL, FILL OUT 1 MEDICAL FORM FOR EACH PERSON, PLEASE