PERSONAL DETAILS FORM

The details below are very important in the event of an accident or personal injury. Please fill in correctly and completely.

NAME:_____ _____

ADDRESS:_____ POSTCODE:_____

PHONE NUMBERS: _____ D.O.B._____

NEXT OF KIN NAME (Not on Trip): _____

ADDRESS:_____ POSTCODE:_____

PHONE NUMBERS:_____ Relationship:_____

DOCTOR NAME:_____ _____

ADDRESS:_____ PHONE:_____

_____

MEDICARE NO:_____ PRIVATE HEALTH INSURANCE:_____

AMBULANCE NO:_____ INSURER:_____

BLOOD TYPE:_____ MEMBER NO:_____

Do you want to be treated as a Private Patient? Y / **N** (Please Circle)

If NO, Private Health insurance details should not be passed to the authorities

MEDICATION:_____

KNOWN ALLERGIES:_____

OTHER:_____