

**Richmond Fellowship Out and About
Medical Information**

AUTHORITY TO RELEASE INFORMATION

I, _____
(Clients Name)

Authorise, _____
(Referrers Name)

Of _____
(Agency)

To release relevant information to this referral to the Out and About Program of
Richmond Fellowship.

Applicant's Signature: _____

Witness: _____

DATED THIS _____ *DAY OF* _____ 20_____

Name: _____

Home Address: _____

Medical Information

Gender: _____

In Case of Emergency, Please contact:

Name: _____

Relationship: _____

Address:

Home Phone: _____ Work Phone: _____

Doctors Name: _____

Doctors Phone: _____

The following medical information may help in the unlikely event of an accident or illness. Please complete this form as accurately as possible. The information you disclose will be confidential and will only be used to help staff respond to any injury or illness.

Do you suffer any medical conditions requiring regular or intermittent medications or injections? If so, please indicate:

Arthritis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Bleeding Condition	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Other (please state)	<input type="checkbox"/>		

2. If you have intermittent medications, state nature, dose and frequency of usage:

3. Are you allergic to any drug? ----- If so, please indicate.

4. Are you allergic to any foods or other substances? If so, list them and describe allergic reaction.

5. Do you have a history of heart problems? If so, describe and state limitations:

6. Do you have any disabilities? If so, please describe.

7. Do you have any fears or phobias? If so, please list.

8. Have you had a Tetanus Toxin injection? _____

If so indicate when:

Within the last 2 years within last 10 years More than 10 years ago

9. Please state any other information which you feel may be required.

Signature: _____

Date: _____