

CONFIDENTIAL MEDICAL FORM



This is collected to assist staff in the event of an emergency.
Please take time to complete this to the best of your ability.

Name: _____

Tel: _____ Mobile: _____ E-mail: _____

Address: _____

Date of Birth ____/____/____

Do you suffer from any allergies? Yes No
If Yes please advise type & severity _____

Do you suffer from any of the following medical conditions?

Asthma Yes No Severity _____

Diabetes Yes No

Epilepsy Yes No

Other, please state: _____

Medication you are currently taking: _____

Tetanus Injection up to date Yes No

Dietary Requirements: _____

Emergency Contact _____

Relationship to you _____

Contact number Home / Work & Mobile: _____

I confirm that the above information is correct to the best of my knowledge and will advise staff if any of this information changes.

Signature: _____ Date: _____

Please return form to:
Pacific Islands Centre, University of Otago, PO Box 56, Dunedin / pacific@otago.ac.nz