Kingdom of Lochac
Chirurgeonate
Participant Medical Information Form

Completion of this form is voluntary and confidential but will assist chirurgeons in providing appropriate care.
When completed, this form is to be secured at all times unless required.
Details on this form will only be given to medical authorities if you are unable provide them due to incapacity. If you have any concerns, please discuss them with the Chirurgeon-in-Charge.

Surname: _____ Given Names: _____
Address: _____
_____
Contact No: _____ Gender : _____ Date of birth: _____
Parent/Guardian: _____ Age (if minor): _____
Medicare No : _____ Expiry date : _____
Private Health Insurer : _____ Number : _____ Expiry date : _____
_____
SCA Name: _____ Member No: _____ Expiry date: _____
SCA Group: _____

Next of Kin: _____
Relationship: _____ Contact No: _____

Do you have any of the following? (Please tick all that apply)

- ☐ Anaemia or other blood disorder (please specify)
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Autism Spectrum Disorder (please specify)
- ☐ Chronic Respiratory problems
- ☐ Chronic Pain (please specify cause)
- ☐ Communicable Disease (please specify)
- ☐ Diabetes (please specify Type 1 or Type 2)
- ☐ Epilepsy or other forms of seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hearing problems
- ☐ Heart Problems (please specify)
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mental Health Condtions (please specify)
- ☐ Migraine
- ☐ Pace maker or in-built defibrillator
- ☐ Pregnancy (please specify due date)
- ☐ Thyroid problems
- ☐ Ulcers
- ☐ Vision problems (please specify)
- ☐ Other (please provide details)

Do you wear any form of medical alerting device? Where is it normally located?

Are you currently taking any prescription, non-prescription, or complimentary medications? Please specify.

Are you aware of any side effects of or interactions with your current medications? Please specify.

Have you had any surgery in the last six to twelve months? If, so please specify any precautions we should take.

Are there any special requirements that you have? If so, how can provide appropriate support for you?

Do you have a current legal 'DNR', 'NFR', or Advanced Health Directive? Please show this to the Chirurgeon-in-Charge for recording.

Is there anything else that you wish to discuss with the Chirurgeon-in-Charge that should be noted on this form. Please specify.

The Society for Creative Anachronism and the event venue do not assume legal responsibility for the information provided on this form. By completing this form you agree to the release of this information to medical authorities in the case of a medical emergency.

Full name:	Signature:	Date:
Duty Chirurgeon to witness:	Signature:	Date:

File a copy with Event Report, retain original securely with the Chirurgeon-in-Charge.
To be treated with confidentiality in accordance with local law. Updated April 2015.