

MEDICAL RECORD

Name:
Address:
.....
State:Post Code:
Next of Kin:
Phone:
Doctor's Name:
Phone

Medical Condition:
.....
.....

Medication:
.....
.....

**Please complete the above information
and place in a sealed envelope with
your name on the front and send to the
National Treasurer with your Registration.**

**This will only be opened in a
Medical emergency**

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