

MEDICAL DECLARATION

Paddler Full Name	_____	ID:	_____
Club Name: CAIRNS BEACHES OUTRIGGER CLUB INC	_____	Zone / State: NQ ZONE	_____

Generic name of medication and dosage (RN): _____

Method of administration: _____

Indications for use: _____

Prescribing Physician: _____

Medical council registration Number: _____ **Phone:** _____

E-mail : _____ **Fax :** _____

Physician's Address: _____

Physician Signature: _____ **Date :** _____

Paddler's consent to provide a copy of this medical declaration to the Australian Sports Drug Agency,

I, _____

agree to AOCRA Inc passing on this medical certificate or record thereof, provided by me for the purpose of complying with the doping control regulations of AOCRA INC. as are current and for that purpose only :

Paddler Signature: _____ **Date :** _____

Parent / Guardian Signature: _____ **Date :** _____
(if paddler under 18 years)