



National Lucie Saronova Memorial Award

National Medical Form

Please complete the following and return with your application form.

Please supply your Medicare No:..... Expiry Date:.....

In the event of an emergency do we have permission to seek medical assistance? Yes No

Are you an Ambulance Subscriber? If so please provide Membership No:.....

All associated medical expenses are the responsibility of the candidate and/or their guardian.

Accommodation address and telephone number whilst in Host State:

.....

Any special dietary requirements: No. Yes. (Please detail)

.....

Allergies:

Emergency contact telephone numbers:

I agree to abide by the rules and regulations of this competition. I understand that no responsibility will be taken for injuries sustained over the duration of the competition.

Competitors Signature: dated:

Parent/Guardian Signature: dated:

*****This application form must be completed and forwarded via the State LSMA Representative to the National Secretary by June 1st or earlier as set by your State*****



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