CORPORATE - WEDDINGS - SCHOOLS
BOOKINGS: 072 289 7466
FAX: 086 572 7408
E-MAIL: anita@konka.co.za

PO Box 120 | Waterfall Mall | 0323

GENERAL
OFFICE: 014 597 5955/6/7/8
FAX: 086 524 4640
E-MAIL: office@konka.co.za

MEDICAL FORM

This form must be completed by the parent or guardian of the participant visiting Konka.

PARTICIPANT'S DETAILS			
Participant's Full Name			
Participant's Date of Birth	(dd/mm/yy)		
Father / Guardian Name		Mother / Guardian Name	
Tel (H)		Tel (H)	
Tel (W)		Tel (W)	
Cell		Cell	

ALTERNATIVE CONTACT PERSON					
Name					
Relation to participant					
Tel (H)		Tel (W)		Cell	

MEDICAL AID DETAILS It is important that all participants have adequate medical cover. Select with X where applicable.							
Medica l Aid		Medical Insurance		Hospital Plan		Travel Insurance	
Medical Aid				Fund Number			
Type of Fund				Main Member			
MEDICAL CONDITIONS Mark with X where applicable							
ADHD		Heart problems		Bleeding		Asthma	

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Epilepsy		Allergies (provide details)		Other	
Desc ription of any medication the participant will take during his/her visit to Konka:					