2025 Bangarra Dance Theatre
Medical Form (3 pages)

MEDICAL INFORMATION

Personal details

Full Name: _____

Male/Female/Non-binary (circle) DOB:

Contact number: _____

Email:

Postal address: _____

_____

IMPORTANT. We ask that you read the statement below, and if you have any questions please feel free to contact us at: HRmanager@bangarra.com.u

Disclosure of medical information is at your own discretion. The purpose for gathering this information is so that we are aware of any existing or potential physical and/or mental health issues that might require appropriate attention or adjustments should you be shortlisted to attend the audition.

Please read our Privacy statement

Dance training and injury/medical history

1. Number of years spent training in dance *Part-time:* _____ *Full-time:* _____

2. Are you fully vaccinated for Covid-19? Yes / No

    a. If yes, are you able to provide your proof of vaccination certificate? (Please note, as a touring company member you may be required to have proof of vaccination for some work places and remote communites) Yes / No

3. Do you have any current medical issues? (E.g. asthma, diabetes, heart problems etc.) Yes / No
   If yes, what is the nature of these issues? _____

_____

_____

4. Do you take any regular medications? Yes / No
   If yes, please list: _____

_____

_____

_____

5. Do you have, or have you had any past mental health issues? Yes / No

If yes, what is/was the nature of these issues? _____

_____

_____

_____

6. Have you had any surgery? Yes / No

If yes, please provide any relevant information regarding the purpose and outcome of the surgery:

_____

_____

_____

_____

7. Have you had any fractures or dislocations? Yes / No

If yes, please provide details of past fractures/dislocations: _____

_____

_____

8. Are you suffering / have you suffered any injuries that have caused you to modify your dancing for longer than 1 week? Yes / No

Injury: _____

Date of injury: _____

Incident: _____

Any residual problems? _____

_____

Injury: _____

Date of injury: _____

Incident: _____

Any residual problems? _____

_____

Injury: _____

Date of injury: _____

Incident: _____

Any residual problems? _____

_____

Injury: _____

Date of injury: _____

Incident: _____

Any residual problems: _____

_____

I declare that the information I have provided on this Medical form is true and accurate.

Name: _____

Sign: _____ Date: _____

If under the age of 18 years we require a parent/guardian to co-sign this document.

Name: (parent/guardian): _____

Sign: _____ Date: _____