

# Player Medical Information Sheet

Name: \_\_\_\_\_

Date of Birth: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Provincial Health Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Business phone Number: Mother: \_\_\_\_\_ Father: \_\_\_\_\_

**Person to contact in case of accident or emergency, if parents are not available.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W/C) \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Please circle the appropriate response below pertaining to your child:**

Yes/No Previous history of concussions

Yes/No Medication

Yes/No Fainting episodes during exercise

Yes/No Allergies

Yes/No Epileptic

Yes/No Wears a medic alert bracelet or necklace

Yes/No Wears contact lenses

Yes/No Does your child have any health problems that would interfere with participation on a soccer team?

Yes/No Wears dental appliance

Yes/No Hearing problem

Yes/No Surgery in the last year

Yes/No Asthma

Yes/No Trouble breathing during exercise

Yes/No Has been in hospital in the last year

Yes/No Heart condition

Yes/No Diabetic

Yes/No Has had injuries requiring medical attention in the past year

Yes/No Has had an illness lasting more than a week in the past year

Yes/No Presently injured

**Please give details below if you answered "yes" to any of the above items. {Use separate sheet if necessary}**

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Recent Injuries: \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_

Any information not covered above: \_\_\_\_\_

Date of last complete physical examination: \_\_\_\_\_

\*Any medical condition or injury problem should be checked by your physician before participating in a sports program.

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted; team management will take my child to hospital/M.D. if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination investigation and necessary treatment of my child. I also authorize release of information to appropriate people [coach, physician] as deemed necessary.

Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_