# Player Medical Information Sheet

Player Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Jersey #: \_\_\_\_\_\_\_\_ Team name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Day: \_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ Prov: \_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_

Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 | Diabetic |
| Yes No | Fainting episodes during exercise | Yes No | Medication |
| Yes No | Epileptic | Yes No | Allergies |
| Yes No | Wears glasses | Yes No | Wears a medic alert bracelet or necklace |
| Yes No | Are lenses shatterproof | Yes No | Any health issues that interfere with playing soccer? |
| Yes No | Wears contact lenses | Yes No | An illness lasting more than a week in the last year |
| Yes No | Wears dental appliance | Yes No | Surgery in the last year. |
| Yes No | Hearing problem | Yes No | Has been to hospital in the last year |
| Yes No | Asthma | Yes No | Any injuries requiring medical attention in past year |
| Yes No | Trouble breathing during exercise | Yes No | Presently injured |
| Yes No | Heart condition |  |  |

Please give details below if you answered “Yes” to any of the above items.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use reverse of sheet if necessary

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

Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last complete physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Tetanus Shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

I acknowledge and understand the risks taken by him/her during OTFC soccer practices and games. I assume complete responsibility for those risks and for personal injuries and accident of any kind. I further agree to waive any claims that may arise from his/her participant in OTFC soccer. I understand that it is my responsibility to keep 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 or M.D. if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination and 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 or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_