

# Wasaga Beach Soccer Club

## Player Medical Information Form

General Information

Player Name :		Team .	
Address:		D.O.B.	
Mother's Name:		Cell Phone:	
Father's Name:		Cell Phone:	
Emergency contact if parents are not available/unreachable:			
Name:		Phone:	
		Relationship:	

Pre-Existing Health Conditions – Please check all that apply

Asthma	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>
Inhaler	<input type="checkbox"/>	Presently injured	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	Allergies – Food or other	<input type="checkbox"/>
Epileptic	<input type="checkbox"/>	Epi-Pen	<input type="checkbox"/>
Prescription Eyewear	<input type="checkbox"/>	History of concussions	<input type="checkbox"/>
Hospitalized in the last year	<input type="checkbox"/>	Medic Alert bracelet/necklace	<input type="checkbox"/>
Currently taking medication	<input type="checkbox"/>	Depression/Mood Disorder	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	Hearing Issues	<input type="checkbox"/>

Please provide details on any checked items from above and/or information about any conditions not included above.

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Immunizations – Please indicate Yes or No. If yes, please indicate date or 'unknown':

Tetanus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date/Unknown: _____
Measles/Mumps/Rubella	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date/Unknown: _____
Hepatitis A/B	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date/Unknown: _____

Any medical condition, injury or suspected health issue should be checked by a physician before participating in a soccer program. I understand that it is my responsibility to advise the Team Management and WBSC immediately if there is a change in any of the above information. In the event of a medical emergency, Team Management has permission to provide immediate First Aid as required and to take or have my child taken by EMS to hospital if deemed necessary.

I hereby authorize the physician and nursing staff of the medical institution to which my child is taken to undertake examination investigation and necessary treatment of my child. I authorize the information on this form to be released to appropriate parties (physician, nurse, team first aid, team coach) as deemed necessary.

Signature of Parent/Guardian:	Date: