



## Camrose and District Soccer Association Medical Form

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

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Health Care Number: \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

Do you have any allergies to medications? \_\_\_\_\_

If yes please list \_\_\_\_\_

Do you have any other allergies?

Do you have Diabetes?

Do you have Asthma?

**\*Please ensure player always has their inhaler with them.**

**\*\*If possible please give 1 to the manager for the first aid kit for emergency situations.**

Do you wear a dental appliance?

Do you wear contact lenses?

In case of an emergency are there any other medical conditions a doctor should know about?

**In case of an emergency, NOTIFY (Please list someone other than yourself)**

\_\_\_\_\_

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

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Work: \_\_\_\_\_ Work: \_\_\_\_\_

Home: \_\_\_\_\_ Home: \_\_\_\_\_

Cell: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_ E-mail: \_\_\_\_\_

Due to FOIP, these files will be kept confidential to bench personnel ONLY during the season and destroyed the end of the season.