



## PLAYER MEDICAL INFORMATION

Name:	Alternative Emergency Contact (if parents are not available)
Date of Birth: Day:                      Month:                      Year:	Name:
Address:	Relationship to Player:
Postal Code:	Telephone: (    )                                      Cell: (    )
Telephone: (    )                                      Cell: (    )	Doctor Name:
Provincial Health Number (optional):	Contact Number: (    )
Parent/ Guardian #1 Name:	Dentist Name:
Contact Number: (    )	Contact Number: (    )
Parent/ Guardian #2 Name:	Date of Last Physical Examination:
Contact Number: (    )	<i>Before a player participates in a soccer program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician.</i>

**Please check the appropriate response and provide details below if you answer "yes" to any of the questions.**

Yes <input type="checkbox"/> No <input type="checkbox"/> Medication	Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/> Health problem that would interfere with soccer
Yes <input type="checkbox"/> No <input type="checkbox"/> Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/> Trouble breathing during exercise	Yes <input type="checkbox"/> No <input type="checkbox"/> Has had an illness that lasted more than a week requiring medical attention in place year
Yes <input type="checkbox"/> No <input type="checkbox"/> Previous History of concussions	Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/> Has had injuries requiring medical attention in past year
Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting or seizure during or after physical activity	Yes <input type="checkbox"/> No <input type="checkbox"/> Palpitations or racing heart	Yes <input type="checkbox"/> No <input type="checkbox"/> Been admitted to hospital in the last year
Yes <input type="checkbox"/> No <input type="checkbox"/> Near fainting/ Brownout	Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of heart disease	Yes <input type="checkbox"/> No <input type="checkbox"/> Surgery in the last year
Yes <input type="checkbox"/> No <input type="checkbox"/> Seizures and/ or epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of unexplained death of a young person	Yes <input type="checkbox"/> No <input type="checkbox"/> Presently injured <i>Provide details below.</i>
Yes <input type="checkbox"/> No <input type="checkbox"/> Wears glasses	Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes (circle)- <i>Type 1 or Type 2</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinations up to date
Yes <input type="checkbox"/> No <input type="checkbox"/> If wearing glasses are lenses shatterproof	Yes <input type="checkbox"/> No <input type="checkbox"/> Wears medical information bracelet/ necklace <i>Provide details below.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing challenges
Yes <input type="checkbox"/> No <input type="checkbox"/> Wears contact lenses	Yes <input type="checkbox"/> No <input type="checkbox"/> Wears dental appliance	

**Please give details if you answered "yes" to any of the above (use separate sheet if necessary).**

Medications:	Recent Injuries:
Allergies:	Any information not covered above:
Medical Conditions:	

I understand that it is my responsibility to keep my soccer Association/ Club and/ or its Team Volunteer advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation, and necessary treatment of my child. I also authorize the release of information to appropriate people (coach, physician) as deemed necessary.

Date:	Name of Parent/ Guardian:	Signature:
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