Lacombe Soccer Club 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.