HEAVENS ELEVEN FOOTBALL CLUB

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 AFC 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 AFC 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:*** _____