

“THUMBS UP” SOCCER

Medical Form

All information is kept confidential and only necessary information will be imparted to the head coach.

First Name: _____

Last Name: _____

Address: _____

Phone: _____ Birthdate _____ M/F ____

In case of emergency contact: _____

Relationship: _____

Phone _____

Health Card: _____ Version Code _____

Doctor's Name & Phone _____

Medical Information

Diabetic: no ___ yes ___ Treatment: diet ___ pill ___ injection _____

Asthma: no ___ yes ___ Cerebral Palsy: no ___ yes ___

Heart condition present: no ___ yes ___ (specifically) _____

Any other diagnosis not listed: _____

Down syndrome: no ___ yes ___ Alantoaxial X-ray date: _____
Positive _____ Negative _____

Seizures: no ___ yes ___ (if yes, please fill out next line)

Type _____ Frequency _____

Treatment _____

Hep B Immune: no ___ yes ___ don't know _____

Tetanus shot: no ___ yes ___ date: _____

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Allergies (please list)

Food: _____

Drugs: _____

Other _____

Does the participant have or use any of the following:

Glasses ____ Hearing Aid ____ Dentures ____

Contact lenses ____ Prosthesis ____ Other _____

Medication (self administered) Yes ____ No ____

Name & Dosage _____

Name & Dosage _____

Name & Dosage _____

Comments which would enhance the applicant's participation in the program:

Are there any limitations for the applicant to take part in the program?

Relationship to Applicant (circle one) Parent Guardian Caregiver

** I acknowledge that all information given on this form is correct, to the best of my knowledge, and that I will update this information as it changes:

Signature of Parent/Guardian/Caregiver

Name of person completing form