



# Player Medical Information

For Office Use Only

Team: \_\_\_\_\_

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Player Name: \_\_\_\_\_ DOB: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

MB Health Number: \_\_\_\_\_ Weight: \_\_\_\_\_ Yrs. Exp.: \_\_\_\_\_  
(9 digit number)

\*\*\*\*\*  
Mom: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_

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

Dad: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_

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

Emergency contact, if parent not available:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
\*\*\*\*\*

**Please circle Yes only if any of these pertain to your child**

- |     |   |     |                          |
|-----|---|-----|--------------------------|
| Yes | History of concussions                                | Yes | Epilepsy                 |
| Yes | Glasses/Contact lenses                                | Yes | Hearing problem          |
| Yes | Asthma  | Yes | Heart Condition          |
| Yes | Diabetic  | Yes | Medication               |
| Yes | Allergies (Please specify below)                      | Yes | Surgery in the last year |
| Yes | Injuries requiring medical attention in the past year |     |                          |

If you answered "Yes" to any of the above please provide details:

\_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Any additional information: \_\_\_\_\_

\*Any medical condition or injury problem should be checked by your physician before participating in a football program

I understand that it is my responsibility to keep the team management advised of any changes 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/M.D. if deemed necessary.

I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_