2019 - ST. CATHARINES CLUB ROMA SOCCER
PLAYER MEDICAL INFORMATION SHEET

Player name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: _____

OHIP Card Number: (optional)_____

Mother's Name:_____ Father's Name: _____

Cell Telephone #: Mother _____ Father _____

Person to contact in case of accident or emergency, if parents are not available:

Name: _____ Telephone: _____

Address:_____

Please circle the appropriate response below pertaining to the player:

Yes	No	Previous history of concussions
Yes	No	Fainting episodes during exercise
Yes	No	Epileptic
Yes	No	Wears glasses
Yes	No	Wears contact lenses
Yes	No	Hearing problem
Yes	No	Asthma
Yes	No	Trouble breathing during exercise
Yes	No	Diabetic
Yes	No	Medication
Yes	No	Allergies
Yes	No	Wears a medic alert bracelet or necklace.
Yes	No	Has had injuries requiring medical attention in the past year.

Please give details below if you answered "Yes" to any of the above items.

_____

_____

_____

Medications: _____

Allergies: _____

Medical conditions: _____

Recent Injuries: _____

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 understand that it is my responsibility to keep the team management advised of any change in the above information.

I also authorize release of information to appropriate people (coaches) deemed necessary.

Date: _____ Signature of Parent or Guardian: _____

Print Name please: _____