**Quinte West Wolverines**

**Player Medical Information Sheet**

Name: _____
Date of Birth: Day _____ Month _____ Year _____
Address: _____
Postal Code: _____ Telephone: _____
Mother's Name: _____ Father's Name: _____
E-Mail Address: _____
Business Telephone Numbers: Mother: _____ Father: _____
Person to Contact in Case of Accident or Emergency, if parents are not available:
Name: _____ Relationship: _____
Address: _____ Telephone #: _____
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 | Fainting Episodes During Exercise |
| Yes | No | Epileptic |
| Yes | No | Wears Glasses |
| Yes | No | Are Lenses Shatterproof? |
| Yes | No | Wears Contact Lenses |
| Yes | No | Wears Dental Appliance |
| Yes | No | Hearing Problem |
| Yes | No | Asthma |
| Yes | No | Trouble Breathing During Exercise |
| Yes | No | Heart Condition |
| Yes | No | Diabetic |
| Yes | No | Has Had An Illness Lasting More Than a Week in the Past Year? |
| Yes | No | Medication |
| Yes | No | Allergies |
| Yes | No | Wears a Medic Alert Bracelet or necklace |
| Yes | No | Does Your Child Have Any Health Problems that would Interfere With the Participation on a Soccer Team? |
| Yes | No | Surgery in the last Year |
| Yes | No | Injuries Requiring Medical Attention in the Last Year? |
| Yes | No | Presently Injured |

If you answered "Yes" to any of the above items, please provide details below (use separate sheet, if necessary):

_____
_____
_____
_____
_____
_____
_____

Medications: _____
Allergies: _____
Medical Conditions: _____
Recent Injuries: _____
Last Tetanus Shot: _____

Any Information Not Covered Above:

_____
_____
_____
_____
_____

Date of Last Complete Physician Examination:

_____

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 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 hereby authorize the Physician and Nursing Staff to undertake examination, investigation and necessary treat of my child.
I also authorize release of information to appropriate people (Coach, Physician, Trainer, and Manager) as deemed necessary.

Signature of Parent or guardian: _____ Date: _____