MYERSRIDERSFOOTBALLCLUB

MEDICAL INFORMATION		
PLAYERS NAME:		
HEALTHCARDNUMBER:	**Medical Doctors Name:**	**Phone #:**

Please Circle Below:		**Provide details to YES Answer:**	
Yes	**NO**	**Allergies**	
Yes	**NO**	**Asthma**	
Yes	**NO**	**History of Concussion**	
Yes	**NO**	**Do you wear Glasses**	
Yes	**NO**	**Are the Lenses Shatterproof**	
Yes	**NO**	**Do you wear Contact Lenses**	
Yes	**NO**	**Do you wear a Dental Appliance**	
Yes	**NO**	**Do you wear a Hearing Aid**	
Yes	**NO**	**Heart Condition**	
Yes	**NO**	**Diabetes**	
Yes	**NO**	**Are you taking any Medications**	
Yes	**NO**	**Are you presently injured**	

Please list previous surgeries:
Please provide any information not covered above:

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP THE TEAM MANAGEMENT ADVISED OF ANY CHANGES IN THE ABOVE MEDICAL HISTORY INFORMANTION, AS SOON AS POSSIBLE, AND IN THE EVENT NO ONE CAN B E CONTACTED, TEAM MANAGEMENT WILL TAKE MY CHILD TO THE HOPISTAL, IF DEEMED NECESSARY.

I HEREBY AUTHORIZE THE PHYSICIAN AND NURSING STAFF TO UNDERTAKE EXAMINATION, INVESTIGATION AND NECESSARY TREATMENT OF MY CHILD.

I AUTHORIZE RELEASE OF INFORMATION TO APPROCIATE PEOPLE (COACH, MANAGER, TRAINER, PHYSICIAN ETC) AS DEEMED NECESSARY.

Signature pf Parent / Player Over 18 Years of Age Date:

EMERGENCYCONTACTINFORMATION

NAME: _____ ☐ **MALE** ☐ **FEMALE**

TELEPHONE: **Home-** _____ **Work-** _____

Cell- **Other-**