

MYERS RIDERS FOOTBALL CLUB

– MEDICAL –

The Myers Riders Football Club acknowledges **Mona B. Allan, RN** for the production of this form.

- MITE
- TYKE
- MOSQUITO
- PEEWEE
- BANTAM

PLAYER INFORMATION	
NAME:	_____
ADDRESS:	_____
CITY:	_____ PROVINCE: _____
POSTAL CODE:	_____
TELEPHONE: Home-	_____
Cell-	_____
EMAIL:	_____
DATE OF BIRTH:	_____ (DD-MM-YYYY)
HEALTH CARD NUMBER:	_____

- BANTAM OVFL
- JUNIOR OVFL
- SENIOR OVFL
- JR. RIDERS
- OTHER

PARENT / GUARDIAN #1 INFORMATION	
NAME:	_____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
TELEPHONE: Home-	_____ Work- _____
Cell-	_____ Other- _____
EMAIL:	_____

PARENT / GUARDIAN #2 INFORMATION	
NAME:	_____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
TELEPHONE: Home-	_____ Work- _____
Cell-	_____ Other- _____
EMAIL:	_____

EMERGENCY CONTACT INFORMATION	
NAME:	_____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
TELEPHONE: Home-	_____ Work- _____
Cell-	_____ Other- _____

PAST MEDICAL HISTORY: Have you experienced any of the following?

Heart Murmur	Yes	No	Concussion	Yes	No
Heat Exhaustion	Yes	No	Asthma	Yes	No
Dizziness or Fainting with Exercise	Yes	No	Past Surgery or Hospitalization	Yes	No
Chest Pain or Palpitations	Yes	No	Other Medical Problem(s)	Yes	No
Have you ever been restricted from participating in sports due to a medical problem?				Yes	No
If you answered "Yes" to any of the above, please elaborate in this space...					

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IMMUNIZATION:

Are your immunizations (e.g. tetanus, hepatitis) up-to-date? YES NO

NUTRITION:

Do you consume energy drinks (e.g. Red Bull, Rockstar)? YES NO

SENSORY AIDS:

Do you wear glasses?	Yes	No	During sport?	Yes	No
Do you wear contact lenses?	Yes	No	During sport?	Yes	No
If you require any other sensory aids (e.g. hearing), please elaborate in this space...					

MEDICATIONS & ALLERGIES:

Have you taken any prescription medications other substances in the past 3 months? YES NO

SUBSTANCE (e.g. Advair Inhaler)	REASON (e.g. Asthma)	CURRENTLY TAKING?	
		Yes	No
		Yes	No
		Yes	No
Please elaborate further in this space, if necessary...			

Do you have any significant food, environmental or medical drug allergies? YES NO

SUBSTANCE (e.g. Penicillin)	MOST RECENT EPISODE (e.g. Childhood, 2010, etc.)	TYPE OF REACTION (e.g. Rash, Vomit, etc.)
Please elaborate further in this space, if necessary...		

MUSKOSKELETAL INJURIES: Please document any past injuries, being as specific as possible...

PAST INJURY (e.g. Broken Left Wrist)	YEAR	STILL A PROBLEM?	
		Yes	No
		Yes	No
		Yes	No
Please elaborate further in this space, if necessary...			

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In the space below, please expand on any items or issues you feel we should be made aware of...

Any medical condition or injury problem should be assessed by a physician prior to participating in a football 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 that no one can be contacted, team management will take my child to hospital/physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, assessment and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician), as deemed to be necessary.

Signature of Parent/Guardian: _____

Date: _____
(DD-MM-YYYY)