

CYSA Club

Player Medical Information Form

General Information

Player Name : _____	Team/Prog. _____
Address: _____	Postal Code: _____
Provincial Health #: _____	D.O.B. _____
Current Weight: _____	Current Height: _____
Mother's Name: _____	Cell Phone: _____
Father's Name: _____	Cell Phone: _____
Emergency contact if parents are not available/unreachable:	
Name: _____	Phone: _____ Relationship: _____
Family Doctor: _____	Phone: _____

Pre-Existing Health Conditions – Please check all that apply

Asthma <input type="checkbox"/>	Heart Condition <input type="checkbox"/>
Inhaler <input type="checkbox"/>	Presently injured <input type="checkbox"/>
Diabetic <input type="checkbox"/>	Allergies – Food or other <input type="checkbox"/>
Epileptic <input type="checkbox"/>	Epi-Pen/Allerject <input type="checkbox"/>
Prescription Eyewear <input type="checkbox"/>	History of concussions <input type="checkbox"/>
Hospitalized in the last year <input type="checkbox"/>	Medic Alert bracelet/necklace <input type="checkbox"/>
Currently taking medication <input type="checkbox"/>	Depression/Mood Disorder <input type="checkbox"/>
Blood Disorders <input type="checkbox"/>	Hearing Issues <input type="checkbox"/>

Please provide details on any checked items from above and/or information about any conditions not included above.
Please indicate any and all allergies or medications:

Immunizations – Please indicate Yes or No. If yes, please indicate date or 'unknown':

Tetanus	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date/Unknown: _____
Measles/Mumps/Rubella	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date/Unknown: _____
Hepatitis A/B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date/Unknown: _____

Any medical condition, injury or suspected health issue should be checked by a physician before participating in a soccer program.

I understand that it is my responsibility to advise the Team Management and OSC immediately if there is a change in any of the above information. In the event of a medical emergency, Team Management has permission to provide immediate First Aid as required and to take or have my child taken by EMS to hospital if deemed necessary.

I hereby authorize the physician and nursing staff of the medical institution to which my child is taken to undertake examination investigation and necessary treatment of my child. I authorize the information on this form to be released to appropriate parties (physician, nurse, coach) as deemed necessary.

Refusal to Complete Medical Information Form (check only if the above information has not been completed)

I understand that by refusing to provide the information requested on this form I am releasing the CYSA of any liability or medical claims resulting from this decision (signature required below).

Signature of Parent/Guardian: _____ Date: _____