SMAA FOOTBALL MEDICAL FORM

CHILD'S NAME ______________________________ AGE ______________________________

ADDRESS ______________________________ PHONE ______________________________

______________________________ POSTAL CODE ____________________

FAMILY DOCTOR ______________________________ ALTERNATE CONTACT NAME____________________

PARENT/
GUARDIAN'S NAME ______________________________ PHONE NUMBER________________________

PLEASE PRINT

PLEASE CHECK THE APPROPRIATE COLUMNS	YES	NO	COMMENTS
Does your child wear a Medic Alert Bracelet?	______	______	____________________
Does your child have Allergies?	______	______	____________________
Does your child have Asthma?	______	______	____________________
Does your child use an Inhaler/Puffer?	______	______	____________________
Does your child have Diabetes?	______	______	____________________
Does your child have Epilepsy?	______	______	____________________
Does your child have any Heart Problems?	______	______	____________________
Is your child currently on or require medication: (e.g. Ritalin, Insulin, etc.) Please specify.	______	______	____________________
Does your child have Vision Problems?	______	______	____________________
Is your child required to wear glasses while playing?	______	______	____________________
Does your child have Hearing Problems?	______	______	____________________
Has your child ever had a Broken Bone? Please specify.	______	______	____________________
Has your child ever had a serious Head Injury?	______	______	____________________
Are there any other problems we should be aware of?	______	______	____________________

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I GIVE MY PERMISSION FOR THE ABOVE MENTIONED CHILD TO BE GIVEN NECESSARY EMERGENCY MEDICAL TREATMENT IN MY ABSENCE

____
DATE

____
SIGNATURE OF PARRENT/GUARDIAN

Please measure the circumference of the players head and insert that measurement here_________________________inches