SMAA FOOTBALL MEDICAL FORM

Child's Name: ____ Age: _________________

Address: ____ Phone: ________________________

____ Postal Code: ____________________

Family Doctor: ____ Doctor Phone:___________________

Parent/Guardian name: _________________________________ Cell: _________________________

Alternate Contact: _________________________________ Phone: _________________________

PLEASE CHECK THE FOLLOWING COLUMNS

Does your child have allergies?	YES	NO	____________________
Does your child wear a Medical Alert bracelet?	YES	NO	____________________
Does your child have an Inhaler/Puffer?	YES	NO	____________________
Does your child have Diabetes?	YES	NO	____________________
Does your child have Epilepsy?	YES	NO	____________________
Does your child have heart problems?	YES	NO	____________________
Is your child currently on OR require medication? (e.g. Ritalin, Insulin, etc.) Please specify.	YES	NO	____________________
Does your child have vision problems?	YES	NO	____________________
Is your child required to wear glasses while playing?	YES	NO	____________________
Does your child have hearing problems?	YES	NO	____________________
Has your child ever had a broker bone? Please specify.	YES	NO	____________________
Has your child ever had a serious head injury?	YES	NO	____________________
Are there any other challenges we should be aware of?	YES	NO	____________________

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

______________________________ ____

DATE SIGNATURE OF PARENT/GUARDIAN

Please measure the circumference of the player's head and provide here: _________________