



2009 FOOTBALL CANADA NATIONAL JUNIOR TEAM

MEDICAL FORM

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND PRINT CLEARLY

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PLAYER INFORMATION

NAME: _____ DATE OF BIRTH (dd/mm/yyyy): (/ / 19)

ADDRESS: _____

CITY/TOWN: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: () - _____

IN THE CASE OF EMERGENCY PLEASE CONTACT: _____

RELATION: _____ PHONE: () - _____

MEDICAL INFORMATION

This information will be kept in confidence and will ONLY be released if required to deal with a medical situation concerning the health and well-being of the athlete.

Medical Number: _____

Family Doctor: _____

Family Doctor Phone Number: _____

Are you taking any medication: Yes No
If yes, please list: _____

Are you taking any supplements: Yes No
If yes, please list: _____

Do you have any allergies to medications: Yes No
If yes, please list: _____

Do you have any other allergies (i.e. bee stings): Yes No



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If yes, please list: _____

Special Diet (i.e. Food allergies, vegetarian): Yes

No

If yes, please list: _____

History of any previous neck or head injuries and/or concussions? Yes

No

If yes, please specify: _____

Medical Conditions (i.e. Heart Condition, epilepsy): Yes

No

If yes, please specify: _____

If yes to either of the two last questions, doctor's clearance is required to play:

Doctor's Name: _____

Doctor's Signature: _____ Date: _____