



# *Lower Island Soccer Association*

Office: 101 – 1246 Esquimalt Road, Victoria, BC V9A 3N8  
Phone: (250)382-7489, Fax: (250)382-7480, Email: lowerislandsoccer@shaw.ca

## **Metro/Select Player Medical Information**

The parents or guardians of all metro/select players must complete this submit this form to the team manager. Information supplied is held in confidence between the coaching staff, those providing medical assistance and the player and parent/guardian.

### **1. Player/Parent Information Section**

Player Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last Name, First Name and Initial) (Day, Month, Year)

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Ph: (250) \_\_\_\_\_ Fax: (250) \_\_\_\_\_ Email: \_\_\_\_\_

Medical Insurance Carrier Name and Number \_\_\_\_\_

Parent/guardian: \_\_\_\_\_  
(Name and Address)

Home Ph \_\_\_\_\_ Cell: \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Other Emergency Contact; \_\_\_\_\_  
(Name, Address and Relationship)

Home Ph \_\_\_\_\_ Cell: \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Family Doctor \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

**2. Medical Conditions:** Please list all medical concerns, prior injuries, prescriptions or other conditions of which the coaching staff should be made aware. If a player has a condition that requires special treatment please provide a complete outline (e.g. allergy to wasp stings, certain medicines or prescriptions, etc.)

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Please use an attached sheet to list additional information.

I understand that medical emergencies may arise that require immediate medical attention for my son or daughter. I hereby provide approval for necessary emergency treatment. I understand that a member of the coaching staff will contact me or another listed contact and, as required, our family doctor at the earliest possible time after the medical situation becomes known.

Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

July 10, 2003