

Lower Island Soccer Association

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District Development Centre Medical Information

The parents or guardians of all District Development Centre players must complete and submit this form. 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: _____ Home Ph _____
(Name, Address and Relationship)

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.)

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)