Ottawa Internationals Soccer Club Inc.
1237 Newmarket Street,
Ottawa, Ontario K1B 5N6

Phone: 613-745-7400 Fax: 613-745-8220

Confidential Player Medical Information Sheet
PRINT ALL INFORMATION

SURNAME - ____________________ First Name - ________________________

Birth Date - ___________________ (yy/mm/dd)

Address - ____

Postal Code - _____________ Home Phone - _____________________________

Mother's Name - ________________ Father's Name - ____________________

Mother's Address – Same ☐ or ____
Father's Address – Same ☐ or ____

Mother's Home Phone – Same ☐ or ____________________
Father's Home Phone – Same ☐ or ____________________

Mother's Work Phone – _________________Father's Work Phone - _________________
Mother's Cell Phone – __________________Father's Cell Phone - __________________

Mother's Email - ____

Father's Email - ____

If parents are not available, person to contact in case of an accident or emergency:

Name - ____________________________________ Relationship to player______________
Home Phone - ________________________________
Cell Phone - _________________________________

Medical History:

Health Card # ____
Doctor's Name - ____
Doctor's Phone # - ________________________

Please circle below:

Yes	No	Allergies
Yes	No	Asthma
Yes	No	Trouble Breathing During Exercise
Yes	No	Previous History of Concussions
Yes	No	Fainting Episodes During Exercise
Yes	No	Epileptic
Yes	No	Wears Glasses
Yes	No	Are Lenses Shatterproof
Yes	No	Wears Contact Lenses
Yes	No	Wears Dental Appliances
Yes	No	Hearing problems
Yes	No	Diabetic
Yes	No	Medication
Yes	No	Presently Injured

Please give details below if you answered "Yes" to any of the items on the previous list:

____

Allergies:
____
____

Medication (available from parent/guardian at all practices/games):
____
____

Recent Injuries:
____
____

Your physician should check any medical conditions, or injury problems, before participating in a soccer program.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP THE TEAM MANAGEMENT ADVISED OF ANY CHANGE IN THE ABOVE INFORMATION, AS SOON AS POSSIBLE, AND THAT, IN THE EVENT NO ONE CAN BE CONTACTED, TEAM MANAGEMENT WILL TAKE MY CHILD TO THE HOSPITAL/MD, IF DEEMED NECESSARY.

I HEREBY AUTHORIZE THE PHYSICIAN AND NURSING STAFF TO UNDERTAKE EXAMINATION, INVESTIGATION AND NECESSARY TREATMENT OF MY CHILD.

I AUTHORIZE RELEASE OF INFORMATION TO APPROPRIATE PEOPLE (COACH, PHYSICIAN, ETC) AS DEEMED NECESSARY.

Signature of Parent or Guardian: ________________________________
Date:_________________________________