PLAYER MEDICAL INFORMATION

PLAYER'S NAME:	D.O.B: / / day month year
ADDRESS:	
TEL #:	HEALTH INSURANCE #:
MOTHER'S NAME:	MOBILE #:
FATHER'S NAME:	MOBILE #:
FAMILY DOCTOR:	TEL #:
IMPORTANT	
Is the player allergic to any drugs, if so what?	
Does the player have any other allergies?	
Does the player suffer from any serious illness? (please tick) 1. Asthma_____ 2. Diabetes____ 3. Epilepsy____ 4. Others____(please advise):	
Is the player on any regular medication, if so what?	
Does the player wear glasses/contact lenses?	
Any other relevant information?	
Signed:	Date: