DOWNRIVER JUNIOR FOOTBALL LEAGUE
MEDICAL HISTORY & INFORMATION

Child Name:____ Date:____________________
Street Address:_____________________________________ D.O.B___________________
City:____ Telephone:________________

EMERGENCY CONTACT (S):

Name:________________________________ Name:________________________________
Relationship:__________________________ Relationship:__________________________
Telephone:____________________________ Telephone:____________________________

FAMILY INSURANCE INFORMATION:

Insurance Company:___________________________ Policy Number:__________________
Policy Holder:_______________________________ Telephone Number:_______________
Family Medical Insurance coverage in effect at this time: Yes No

Please complete the following: If the answer to any question is or was yes, please describe. Please describe the problem and it's implications for proper first aid treatment on the back of this form. Has the child had, or does the child currently have:

Head Injury (concussion, etc.)	Y	N	Fainting Spells	Y	N
Convulsions / Epilepsy	Y	N	Asthma	Y	N
Neck or Back Injury	Y	N	Hernia	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N
Kidney Problems	Y	N	Heart Murmur	Y	N
Poor Vision	Y	N	Poor Hearing	Y	N
Allergies	Y	N	Other:__________________________		

Has the child had, or does the child currently have injuries to:

Shoulder	Y	N	Knee	Y	N	Ankle or Leg	Y	N
Finger	Y	N	Arms	Y	N	Back or Neck	Y	N

Is the child currently taking any medication? Y N

If Yes, what and why:____
____
____

LIST ANY CURENT RESTRICTIONS CURRENTLY PLACED ON THE CHILD'S ACTIVITIES AT THE DIRECTION OF HIS OR HER DOCTOR OR OTHER MEDICAL CARE PROVIDER:____
____
____

Parent / Guardian (Print):____
Parent / Guardian (Sign):____________________________________ Date:______________

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