



# Oceanside Youth Soccer Society

## Medical Information (PLEASE PRINT)

Player's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone : \_\_\_\_\_

Street Address: \_\_\_\_\_

Parent(s) Names: \_\_\_\_\_

Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_

Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_

Family Physician: \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Care Card Number: \_\_\_\_\_ Dental Phone # \_\_\_\_\_

Relevant Medical History: Medications: \_\_\_\_\_

Allergies: Food \_\_\_\_\_ Other \_\_\_\_\_

Injuries: Previous \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Parent/ Guardian

YYYY/MM/DD

COACHES PLEASE NOTE: MEDICAL INFORMATION IS CONFIDENTIAL. KEEP THIS FORM WITH THE TEAM AT ALL TIMES. THIS FORM SHOULD NOT BE AVAILABLE TO OTHERS THAN AUTHORIZED INDIVIDUALS.