



Youth Soccer

Medical Information Sheet

(PLEASE PRINT)

Player's Last Name: _____ First Name: _____

Address: _____ Phone#: _____

Date of Birth: _____

Parent(s) Names: _____

Phone # _____ Cell# _____

Alternate Emergency Contact: _____

Phone # _____ Cell# _____

Family Physician: _____ Physician phone#: _____

Care Card Number: _____ Dental Number: _____

Relevant Medical History: Medications: _____

Food Allergies: _____

Other Allergies: _____

Previous Injuries: _____

Other: _____

Signature of Parent / Guardian: _____

Date: _____

COACHES PLEASE NOTE:
MEDICAL INFORMATION IS CONFIDENTIAL. KEEP THIS FORM WITH THE TEAM AT ALL TIMES.
THIS FORM SHOULDNOT BE AVAILABLE TO OTHER THAN AUTHORIZED INDIVIDUALS.