



Mitchell Rangers Soccer Club Inc.

Confidential Medical Information

This information is intended to assist the coaching staff/ambulance staff in case of any medical emergency that may arise. All information will be held in confidence by the club.

Player name:	Date of birth:	Age this year:
Parent/guardians full name (If under 18):		
Address:		
		Postcode:
Home phone:	Mobile phone:	
Email Address:		
Next of kin name (Adult):		
Next of kin address (Adult):		
		Phone:

Please note that ambulance cover is strongly recommended

Do you the player suffer from any of the following?

Fits of any type: Yes No	Heart conditions: Yes No	Asthma: Yes No
Diabetes: Yes No	Blackouts: Yes No	Migraines: Yes No
Other:		

Asthma: Please provide asthma management plan and ensure asthma medication is at training and games and the team manager is aware of where it is.

Other Conditions: If the player has any other conditions that require a management plan e.g. diabetes, anaphylaxis etc. then you need to also provide a copy of the plan to the club.

Do you the player have any allergies? Yes No

If yes, please list.

What special care is recommended:

Are you the player on any form of ongoing medication that is likely to affect your playing/training?
If so please state:

Consent to Medical Attention

I hereby give permission to the coach/team manager or club management to seek medical or surgical treatment for me or my child (If under 18) at a hospital, or to call a doctor and/or ambulance and / or dentist during an emergency if I am unable to verbally consent myself **and agree to pay all relevant costs involved.**

Parent/guardian or Adult Player Signature:	Date:
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