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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