# Medical Profile

| | |
|---|---|
| Full Name of Player | |

| | |
|---|---|
| Date of Birth | |

| | | | |
|---|---|---|---|
| Parent / Guardian 1 | | Mobile Tel. | |
| Parent / Guardian 2 | | Mobile Tel. | |

| | | | |
|---|---|---|---|
| Doctor's Name | | | |
| Surgery Address | | | |
| | | | |
| County | | Postcode | |
| Telephone | | | |

Do you suffer from any of the following? *If yes, please list all prescribed medication*

| | YES | NO | |
|---|---|---|---|
| Asthma | ☐ | ☐ | |
| Severe headaches or migraine | ☐ | ☐ | |
| Epilepsy | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Nosebleeds | ☐ | ☐ | |
| Allergies to any known drugs | ☐ | ☐ | |

Any other illness or ailment not named above? ☐ YES ☐ NO
*If yes, please give details*

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Are you currently receiving medical treatment? ☐ YES ☐ NO
*If yes, please give details*

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Do you have any current injury concerns? ☐ YES ☐ NO
*If yes, please give details*

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Have you ever suffered concussion? ☐ YES ☐ NO
*If yes, please state date (if known).*

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Have you had a Tetanus vaccination in the last ten years? ☐ YES ☐ NO
*If yes, please state date (if known).*

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Do you wear contact lenses? ☐ YES ☐ NO

Please state any relevant past injuries or significant illnesses

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Please state any relevant family medical history

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Emergency Contact *(please provide an alternative contact to Parent / Guardian listed above).*

| | |
|---|---|
| Name | |
| Relationship to player | |
| Telephone | |

Permission for medical care
I the undersigned, hereby give permission for my daughter to receive medical treatment whilst in the care of Asfordby Amateurs Ladies Girls Football Club .

NB: every effort will be made to contact the parent/guardian in the event of an emergency, but should it be necessary, AALGFC will deal with any medical matter that arises unless told otherwise.

| | | |
|---|---|---|
| Signed | | Parent/Guardian |
| Print Name | | Parent/Guardian |
| Date | | |