

DO NOT MAIL!

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BRING TO FIRST PRACTICE
MIAMI UNIVERSITY YOUTH SOCCER ASSOCIATION
THE "M" LEAGUE

Please fill out this form **COMPLETELY**. It is important for the provision of proper medical care. The section marked "Physician's Comments" need only be completed if the participant has a major health problem. When older participants are seen for minor illnesses or injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the physician will try to contact the parents to inform them of the problem and discuss the treatment. Occasionally, we are unable to reach parents immediately to inform them of a serious problem. The parent's signature on the medical treatment authorization allows us to go ahead with treatment in these circumstances. The local hospital, or a member of the program's staff will continue to call until contact is made with the parent or guardian.

MEDICAL HISTORY

PERSONAL INFORMATION (Please Print)

Social Security # _____

Name: _____ Sex: Male Female
Last First Middle

Home Address: _____
No. Street City State Zip Code

Phone: () _____ Date of Birth: / / _____ Age: _____

In case of emergency, notify: _____
Name of parent or next of kin relationship

Parents E-mail Address _____

Address: _____
No. Street City State Zip Code

Home Phone: () _____ Business Phone: () _____

Business Address of Parent or Next of Kin: _____

If unable to contact either of above, name & phone of another responsible person: _____

Family Physician: _____ Address: _____

Phone: () _____

FAMILY HISTORY

Do you have a **family** history of: (Please Circle)

Diabetes Tuberculosis Cancer Heart Disease Kidney Disease Migraine

PERSONAL HISTORY

Immunization Record - Include Dates

DPT _____ Most Recent Tetanus Booster _____

MMR _____ Polio _____

TB Skin Test (Optional) _____ Have you had the chicken pox? _____

Allergies - particularly to medications - please list:

