2017 EPFC Development Program
Player Medical Information

It is essential that this form be completed accurately and completely as this information is to be used in the event of you requiring medical attention.

Name _____ **Date of Birth**_____ **School Year** _____

Do you suffer from any of the following conditions?

Respiratory Problems	Yes	☐	No	☐
Heart Problems	Yes	☐	No	☐
High blood pressure	Yes	☐	No	☐
Asthma	Yes	☐	No	☐
Epilepsy	Yes	☐	No	☐
Diabetes	Yes	☐	No	☐

Do you have any other existing medical conditions (if so please list)?

_____
_____
_____

Do you have any allergies (if so please list)?

_____
_____
_____

Are you currently taking any over the counter or prescribed medications (if so please list)?

_____
_____
_____

Have you suffered any serious injury in the past 2 years (broken bones, ligament/tendon damage, concussion)?

_____
_____
_____

Is there any other medical information you need to tell us about that will have a bearing on your ability to participate in physical testing or games or that may have an effect on any treatment provided should it be necessary?

_____
_____
_____

I/We declare that the information presented above is true and correct

Signed _____ Date: __ / __ / ____
(player)
Print name _____

Signed _____ Date: __ / __ / ____
(parent/guardian)
Print name _____