

# DOWNRIVER JUNIOR FOOTBALL LEAGUE MEDICAL HISTORY & INFORMATION

Child Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_

Date: \_\_\_\_\_  
 D.O.B: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

**EMERGENCY CONTACT (S):**

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

**FAMILY INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 Family Medical Insurance coverage in effect at this time:

Policy Number: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 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: \_\_\_\_\_