



Olinda-Ferny Creek Junior Football Club

Medical Information Season 2010

(All details are strictly confidential)
ONE FORM PER CHILD

NAME:-----

ADDRESS:-----

----- PHONE:-----

MOTHER'S NAME:----- PHONE:-----

FATHER'S NAME:----- PHONE:-----

DOCTOR'S NAME:----- PHONE:-----

DENTIST'S NAME:----- PHONE:-----

EMERGENCY CONTACTS (If parents are unavailable)

NAME:----- RELATIONSHIP:----- PHONE:-----

NAME:----- RELATIONSHIP:----- PHONE:-----

Does your child suffer from any of the following conditions?

Condition	No	Ye s	Details – Severity/Frequency/Special Treatment Required
Asthma*			
Diabetes			
Epilepsy			
Allergies			
Hay fever			
Visual problems			
Hearing problems			
Headaches			
Kidney problems			
Heart conditions			
Regular medication			
Special needs			
Other			

*** ASTHMA MANAGEMENT PLAN TO BE PROVIDED**

I/We declare that the information above is correct and hereby authorise Olinda-Ferny Creek Junior Football Club Inc, or its recognised representatives, in my/our absence to seek medical assistance for my child if required. I/We understand that I/we shall be responsible for any costs incurred.

Signature(s) of Parent/Guardian----- Date:-----