Oceanside FC
PO BOX 1763, Parksville, BC V9P 2H5
oceansidefc.com

Medical Information
(PLEASE PRINT)

*Player's Last Name:*____________________________ *First Name:*_______________

Date of Birth: ______________________________ *Phone :* ___________________

Street Address: ____

Parent(s) Names: ____

*Phone: Day*________________ *Evening*_______________ *Cell* __________________

*Alternate Emergency Contact:*____

*Phone: Day*________________ *Evening*_______________ *Cell* __________________

*Family Physician:*_____________________ *Physician's Phone #*__________________

*Care Card Number:*___________________ *Dental Phone #*______________________

Relevant Medical History: Medications: _____________________________________

Allergies: Food ________________________ *Other*_______________________

Injuries: Previous ______________________ *Other*_______________________

__________________________________ _______________________

Signature of Parent/ Guardian *YYYY/MM/DD*

COACHES PLEASE NOTE: MEDICAL INFORMATION IS CONFIDENTIAL. KEEP THIS FORM WITH THE TEAM AT ALL TIMES. THIS FORM SHOULD NOT BE AVAILABLE TO OTHERS THAN AUTHORIZED INDIVIDUALS.