



Blenheim Community Soccer League

Medical Information Form

Participant's name: First _____ Last _____ DOB: ____/____/____
YY MM DD

Address: _____

Parent/Guardian's name: _____ Telephone: (____)____-____

Doctor's name: _____ Telephone: (____)____-____

Does the participant have any medical conditions or allergies that we should be aware of?
 Yes No

If yes, please specify and note below any actions that should be taken.

Consent for Emergency Medical Treatment

In the case of an emergency, please contact one of the following individuals.
(please list a parent as one contact)

Emergency Contact Names	Relationship	Home Phone	Alternate Phone
1.		(____)____-____	(____)____-____
2.		(____)____-____	(____)____-____

I understand that it is my responsibility to keep the Blenheim Community Soccer League informed of any changes to the above information as soon as possible.

I hereby give permission for emergency medical treatment to be administered to the above-mentioned child, as may be determined in the reasonable discretion of his/her coach, the convener or designate. It is understood that whenever reasonably possible, someone will be contacted and informed of the condition, treatment required and anticipated medical results.

I also authorize release of information to appropriate people (coach, convener, league personnel, and physician) as deemed necessary.

Parent/Guardian Signature: _____ Date: _____

Please return this form to a member of the Blenheim Community Soccer League.

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the Personal Information Protection Act.