

**ALL COUNTY CONFERENCE JUNIOR FOOTBALL PLAYER MEDICAL
INFORMATION FORM**

NAME: _____ HEIGHT: _____
ADDRESS: _____ WEIGHT: _____
AGE: _____ PHONE: _____
BIRTHDATE: _____ WORK: _____
CELL: _____
E-Mail Address: _____

HAVE YOU BEEN TREATED FOR:

RHEUMATIC FEVER: YES ___ NO ___ LUNG DIS.(ASTHMA) YES ___ NO ___
HEART DISEASE: YES ___ NO ___ NEUROLOGICAL DISORDER: YES ___ NO ___

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DIABETES: YES ___ NO ___
HIGH BLOOD PRESSURE: YES ___ NO ___
POLIO: YES ___ NO ___
ARTHRITIS: YES ___ NO ___
KIDNEY(RENAL) DISEASE YES ___ NO ___
ALLERGIC REACTION (ANAPHALAXIS)
(I.E. INSECTS, BEES, WASPS ETC.) YES ___ NO ___

OTHER: _____

LIST ALLERGIES: _____

LIST CURRENT MEDICATION: _____

FAMILY PHYSICIAN: _____ PHONE: _____

PARENT (S) SIGNATURE: _____

PERSON TO BE CONTACTED IN THE EVENT PARENT IS NOT AVAILABLE

NAME: _____ PHONE: _____

**NOTE: Parents must be available and are required to attend
all practices and games if their child my require medication
administration for a certain condition.**