

VALLEY VIEW BULLDOGS FOOTBALL MEDICAL INFORMATION FORM

NAME _____

HEIGHT _____

ADDRESS _____

WEIGHT _____

CITY _____ PHONE _____

AGE _____

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING: (PLEASE CHECK WHAT APPLIES)

RHEUMATIC FEVER

HIGH BLOOD PRESSURE

POLIO

LUNG DISEASE (ASTHMA)

ARTHRITIS

DIABETES

NEUROLOGICAL DISORDER

KIDNEY RENAL DISEASE

HEART DISEASE

OTHER

IF ANY OF THE ABOVE ITEMS HAVE BEEN CHECKED, A NOTE FROM YOUR DOCTOR WILL BE REQUIRED BEFORE YOUR CHILD WILL BE ABLE TO PARTICIPATE IN THE PROGRAM.

LIST ALLERGIES

LIST OF CURRENT MEDICATIONS

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY PHYSICIAN

NAME _____

PHONE _____

PERSON TO BE CONTACTED IN THE EVENT A PARENT IS NOT AVAILABLE:

NAME _____	RELATIONSHIP _____	PHONE _____
------------	--------------------	-------------

PARENTS SIGNATURE _____	DATE _____	PHONE _____
-------------------------	------------	-------------