

CERTIFICATE OF HEALTH

Players Surname..... Forename.....

Please circle any of the conditions which your child suffers or has suffered from in the past. If you circle Yes to any of the below conditions please add as much information as possible to assist us regarding the care of the player.

Asthma		YES/NO
Other chest / heart		YES/NO
Epilepsy		YES/NO
Blackouts loss of		YES/NO
Ear / Sinus problems		YES/NO
Diabetes		YES/NO
Severe Headaches		YES/NO
Any other illness / injury		YES/NO
Any disabilities		YES/NO
Known allergies		YES/NO
Requires regular care / visits to doctor / hospital		YES/NO
Requires regular medication	If yes please list the medication and fill out the box below.	YES/NO
Medication times and quantity		YES/NO
Special diet restrictions		YES/NO

Details of Players Doctor

Name..... Tel No.....

Address.....

I certify that I will inform the team manager if the player has contact with any infectious diseases in the three weeks prior to the trip. I understand that if a player suffers from asthma they should not take part in prolonged or arduous training within three weeks of a cold and will inform the team manager accordingly. (Training will be structured to meet their needs)

I understand that the adult in charge, after due consideration with a doctor or other member of the medical profession, has the authority to return a player from the trip should they consider it necessary.

Date..... Signature.....

BLOCK CAPITALS (Person having parental responsibility)