

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

NAME: \_\_\_\_\_ HEIGHT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
AGE: \_\_\_\_\_ PHONE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ WORK: \_\_\_\_\_  
CELL: \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_

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**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: \_\_\_\_\_

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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.**