

SWANSEA CITY FOOTBALL CLUB

YOUTH DEPARTMENT

HEALTH QUESTIONNAIRE AND PARENTAL / GUARDIAN CONSENT FORM

CHILD'S FULL NAME ō

ADDRESS ō .

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DATE OF BIRTH ō ō ō ō ō ō ō ō ō ō ō ō ō ō ō .

HOME TEL NO: ō ō ō ō ō ō ō ō ō ō ō ō ō .

MOBILE NO: ō ō ō ō ō ō ō ō ō ō .

EMERGENCY CONTACT NUMBERS

1) ō ō ō ō ō ō ō ō ō ō ō ō ō ō ō .

2) ō ō ō ō ō ō ō ō ō ō ō ō ō ō ō .

NAME and TEL NO of G.P:

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CHRONIC OR EXISTING MEDICAL CONDITIONS (e.g. diabetes, asthma, epilepsy)

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KNOWN ALLERGIES (Please tick)

Anaesthetics

Aspirin

Codeine

Demerol

Antibiotics (Please list)

Insect Stings

IVP Dyes

Morphine

Novocaine

Penicillin

Shellfish

Tetanus Toxoid

Nuts

Sticking Plasters

Vaccinations

CURRENT DAILY MEDICATION õ

RECENT SHOTS and VACCINES

Tetanus (Date) õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

Other (Date) õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

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ANY SPECIAL DIETARY REQUIREMENTS (Please specify)

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If, to the best of my knowledge, my son has been in contact with any infectious diseases or suffered from anything that might become contagious or infectious (within the last four weeks) I will inform the Club.

Do you give permission for Staff to give your son

Aspirin? Yes / No

Paracetamol? Yes / No

Ibuprofen? Yes / No

In the event of an injury, accident or illness incurred by my son, I agree to him receiving all forms of diagnostic testing, medical treatment and surgical procedures considered necessary by a licensed Doctor / Nurse, including the use of anaesthesia and blood transfusions

I will inform the Club (Youth Admin Officer) of any important changes to my son's health, medication or needs and also of any changes of address or the telephone numbers given above.

Name of Parent / Guardian (Please print) o o o o o o o o o o o o o o o o

Signed (Parent / Guardian) o o o o o o o o o o o o o o o o o o

Date o o o o o o o o o o o o ..