ORLEANS AMATEUR FASTBALL ASSOCIATION

MEDICAL DISCLOSURE FORM

I, the undersigned, hereby give permission for my child/ward to fully participate in all OAFA activities (softball games, practices and clinics).

In case of emergency, I hereby give permission to the physician selected by the official in charge to secure proper treatment including hospitalization, drugs, injections, anesthesia, surgery for the child named below.

All information of the player's personal health record, shown below, is true and correct.

Players Name (please print): _____ Date: _____

Parent / Guardian's Signature _____

Parent / Guardian's Name :_____

Phone (home): _____ (work): _____

OHIP # (optional): _____ Family Doctor: _____

Alternate contact: _____ Phone: _____

Indicate by checking if child is subject to or has:
DIABETES ___ HEARING LOSS ___ EPILEPSY ___

DENTAL APPLIANCE ___ ALLERGIES: BEE STING ___PENICILLIN ___ NUTS ___

NOSEBLEEDS ___ HEADACHES ___ ASTHMA ___

NERVOUS DISORDERS ___ HERNIA___ VISUAL DEFECTS ___ HEART PROBLEMS ___

OTHER ALLERGIES (LIST): _____

Previous Injuries: BROKEN ARM: LEFT___ RIGHT ___ SPRAINED ANKLE: LEFT___ RIGHT___

OTHER INJURIES (LIST): _____

Please list any medication or other concerns that the OAFA / medical personnel should be aware of:

_____

NOTE: Medical information is confidential. Keep this form with the team AT ALL TIMES. These forms should not be available to other than authorized individuals.

Revised April 28, 2023