APPLICATION FORM, MEDICAL HISTORY QUESTIONNAIRE & CONSENT FORM

OPEN TRIAL - STEVENAGE FC ACADEMY

PLAYERS NAME	
DATE OF BIRTH	
CURRENT/PREVIOUS TEAM(S)	
POSITION	
FOOTBALL AGE GROUP (e.g U6, U16)	
TIME OF TRAVEL TO SFC ACADEMY	
PLACE OF BIRTH	
NATIONALITY (eg English, Irish, Welsh)	
CURRENT SCHOOL	
YEAR AT SCHOOL	

MAIN EMERGENCY CONTACT

FULL NAME	
RELATIONSHIP TO PLAYER	
FULL ADDRESS	
MOBILE NUMBER	
HOME TELEPHONE	
WORK TELEPHONE	
EMAIL ADDRESS	

In the event that the above named person cannot be reached, please give two extra emergency contact names and numbers

CONTACT 1:	
FULL NAME	
RELATIONSHIP TO PLAYER	
FULL ADDRESS	
MOBILE NUMBER	
HOME TELEPHONE	
WORK TELEPHONE	
EMAIL ADDRESS	
CONTACT 2:	
FULL NAME	
RELATIONSHIP TO PLAYER	
FULL ADDRESS	
MOBILE NUMBER	

HOME TELEPHONE	
WORK TELEPHONE	
EMAIL ADDRESS	

PARENTAL CONSENT

I understand that my son's medical information and records provided on this document records are kept in paper or computer and that they are available only to the medical department of Stevenage Football Club (The Club).

I consent to information from these records being used and processed for or to facilitate the following purposes:

1. In order to establish fitness for selection his records and details of any injuries may be discussed between the medical staff and the recruitment / coaching staff.
2. I also authorise the Academy Medical Staff to provide any emergency treatment of injury or illness suffered by him while he is attending the trial. I understand that the Academy staff will make all reasonable efforts to contact me or other named adult before treatment is commenced.
3. Stevenage FC will not be liable for any costs incurred for any further treatment, apart from the Emergency treatment provided at the time of the incident if applicable.

If any other person or organisation requests access to his notes this will be refused without my prior written consent.

By ticking this box, I confirm that I have read and understood the parental consent outlined above.

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NAME	
RELATIONSHIP TO PLAYER	
DATE	

MEDICAL INFORMATION

FAMILY GP	
SURGERY NAME	
SURGERY ADDRESS	
SURGERY TELEHPHONE	
GP NAME	
MEDICAL HISTORY	
Does your son have any conditions requiring medical treatment?	
If YES, please give details	
Does your son have any known allergies?	
If YES, please give details	
Has your son ever fractured a bone?	
If YES, please give details	
Has your son ever been referred to a hospital consultant or admitted to hospital? **If YES, please give details**	
Has your son ever had any x-rays or scans?	
Has your son ever missed playing football for more than two weeks due to illness or injury?	
If YES, please give details	
Does your son ever become more breathless than his friends on strenuous exertion?	
Has your son ever experienced palpitations either on exercise or at rest?	
Has your son ever had a fit or convulsion?	
Does your son suffer from asthma or diabetes?	
If you have answered YES to any of the above four questions, please give details	
Are there any other illnesses that run in your family?	
If YES, please give details	
Has anyone in your family been diagnosed with a heart condition (under the age of 50)? **If YES, please give details**	

PLEASE NOTE: It is your son's responsibility to bring any prescription medication they have been given (e.g. asthma inhaler) to trial and let a member of staff know where it is.

IMMUNISATIONS

Please indicate which of these immunizations your son has had, and the last date it was given

IMMUNISATION	YES/NO	DATE LAST GIVEN
Tetanus		
Polio		
Whooping Cough		
Diphtheria		
Measles / Mumps / Rubella		
Heamophilus B (Hib)		
Hepatitis A		
Hepatitis B		
BCG		
Meningitis		
Typhoid		

By ticking this box, I confirm that the information provided above is correct to the best of my knowledge.

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NAME **RELATIONSHIP TO PLAYER** **DATE**	