UNITED STATES ASSOCIATION of INDOOR WHEELCHAIR SOCCER
Bill Lardi, Interim Commissioner, bladianddee@verizon.net
1398 Penataquit Ave., Bayshore, NY 11706
Web site: www.usaiws.org

SUPPORT STAFF HEALTH FORM FOR ALL USA-IWS EVENTS, Version 8/26/2010

Team Affiliation: **USA-IWS ID#** **Date:**

Name **Phone(s)**

Address **Date of Birth:**

City **State** **Zip**

Parent/Guardian or Spouse's Name: **Phone(s)**

EMERGENCY CONTACT (If other than above) **Phone(s)**

Name & Relationship **Phone(s)**

Physician's Name: **Phone(s)**

Physician's Address:

Insurance Company: **Policy #**

Do You now have or have ever had any of the following medical/health issues? Circle, Describe if Yes

Allergies	**NO**	**YES**
Drug Allergies	**NO**	**YES**
High Blood Pressure	**NO**	**YES**
Asthma	**NO**	**YES**
Heart Disease	**NO**	**YES**
Diabetes	**NO**	**YES**
Seizures	**NO**	**YES: Type and Last Incident**
Other Health Issues	**NO**	**YES**

Date of Last Tetanus Shot:

Are you currently taking any medications? **NO** **YES**

If Yes Please list:____

It is suggested that you discuss with your physician to obtain his/her approval for your participation in any USA-IWS activity.

In case of an emergency if I am unable to give my permission, I hereby authorize a representative of my team, the tournament organizing committee or the USA-IWS to seek necessary medical care on my behalf. Further, I agree to assume all financial responsibility for such treatment.

SIGNATURE: **DATE:**

SIGNATURE (PARENT/GUARDIAN if UNDER 18 YEARS OF AGE) **DATE:**