



Girls' Health History Form

This form is to be filled in by the parents of the candidate footballer and facilitated by the scouting coordinator prior to joining the Academy.

Contact Information

Name	First	Middle	Last		
Date of Birth	Day (e.g. 01,02..)	Month (e.g. September)	Year (YYYY)		
Mailing Address	Door No.	Building	Street		
	City / Village	State	PIN		
Parent / Guardian(s) Name & contacts	Father		Mother		
	Cell phone number		Cell phone number		
Address if different from Girl's					
Custodian care information (Tick the appropriate box)					
Mother	<input type="checkbox"/>	Father	<input type="checkbox"/>	Both	<input type="checkbox"/>
If an emergency arises, and parent/guardian can't be reached, please contact the following people: (Adult participants, please list emergency contacts here.)					
Contact 1	Name	Phone			
Contact 2	Name	Phone			

Health Information

Name of Family Physician	Phone	
Medical Insurance Provider (Carrier)	Policy Number	
Any other Insurance Provider (Carrier)	Policy Number	
Blood Group (A+/O+/B+/AB+/A-/O-/B-/AB-)		
Immunization records are up to date	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Girls' Health History Form

Date of Last Tetanus shot					
Is the girl fully Vaccinated against COVID 19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If the answer to the above question is "Yes", then please mention the vaccine (Covishield / Covaxine/ Sputnik etc.)					
Date of Last COVID 19 vaccinations					
Date of last health examination					
Were there any medical problems reported?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If the answer to the previous question is "Yes", please elaborate below:					
Does the girl have any physical, mental or psychological condition requiring medication, treatment or other special restrictions or considerations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If the answer to the previous question is "Yes", please state medication and reason below:					
Does the girl take any prescribed medications or over-the-counter drugs on a regular basis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If the answer to the previous question is "Yes", please state medication and reason below:					
In the space provided below, please mention a record of past medical treatment, if any including injuries and/or surgeries:					
The girl has the following health conditions / allergies / dietary restrictions (food and medications):					
<input type="checkbox"/> ADHD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other
<input type="checkbox"/> Allergies (specify)					

Authorization

PARENT/GUARDIAN AUTHORIZATION

This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter/girl should not participate in the prescribed activities of the Debanjan Share Girls' Academy, except as noted. In the event that my daughter/girl needs medical attention while participating in any activity during her tenure with Debanjan Share Girls' Academy, I authorize the adult in charge to see that my daughter/ girl receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed.

Signature of Parent / Guardian

Date

The contents of this form were explained and facilitated by : (Name of DSGA Representative)	Signature



**DEBANJAN
SHARE
GIRLS' ACADEMY**
A collaborative effort of Debanjan Sen Foundation & Share Football Club



Girls' Health History Form
