WMMF MEDICAL DECLARATION FORM

Competition: **Venue:** **Date(s):**

Full Name:	Date of Birth:	Team Name:	Emergency Contact Name:	Emergency Contact Number:

Medical Declaration

Please indicate if you currently suffer from, or have previously suffered from, any of the following medical conditions:

□ Heart condition □ Asthma □Epilepsy □ Diabetes □ Blood Pressure □Bone or joint injury
□ Recent surgery □ Concussion/head injury □ Allergies □ Other medical condition(s)
If yes, please provide details:

Medication

Are you currently taking any medication?

□ Yes □ No If yes, please provide details:

Declaration

I declare that the information provided in this form is true and accurate to the best of my knowledge. I confirm that I am physically fit to participate in WMMF activities and competitions. I understand that participation in sport carries inherent risks of injury and that I am responsible for informing competition officials of any changes to my medical condition.

Player Signature: Date:

For players under 18 years of age:
Parent/Guardian Name: Signature: Date: