



PLAYER MEDICAL INFORMATION FORM

Players Name: _____

Date of Birth: _____

Street Address: _____

City: _____ Postal Code: _____

Mother's Name: _____ Father's Name: _____

Telephone: _____ (H#) _____ (B#) _____ (Cell#) _____

Doctor's Name: _____ Telephone: _____

Date of Last Physical: _____ Date of Last Tetanus Shot: _____

Dentist's Name: _____ Telephone: _____

Medical conditions (i.e. Diabetes, Epilepsy): _____

Please circle the appropriate responses below pertaining to the athlete

- Yes No Medications List: _____
- Yes No Allergies List: _____
- Yes No Wears a medic alert bracelet or necklace
- Yes No Glasses Are the lenses shatterproof? Yes No
- Yes No Wears contact lenses
- Yes No Asthma
- Yes No Trouble breathing during exercise
- Yes No Fainting episodes during exercise
- Yes No Previous history of concussions
- Yes No Wears dental appliance
- Yes No Has had an illness lasting more than a week in the past year
- Yes No Previous serious injury or illness requiring medical attention in the past year
- Explain: _____
- Yes No Previous surgeries List: _____
- Yes No Previous hospitalizations List: _____

Alternate contact in case of accident or emergency, if parents are not available.

Name: _____ Telephone: _____

The athlete's physician should clear all medical conditions and/or injuries before participating in any sports program.

I understand that it is my responsibility to notify the team management of any change in the above information. In the event no one can be contacted, team management will take my child to hospital if deemed necessary. I authorize release of information to the appropriate people (coach, manager, physician) as deemed necessary.

Signature of Parent/Guardian: _____ Date: _____