

PLAYER MEDICAL INFORMATION:

PLEASE NOTE THAT IF THIS FORM IS NOT FILLED OUT AND RETURNED TO THE COACH, PLAYER WILL NOT BE ALLOWED TO PLAY UNTIL COMPLETED.

NAME DATE OF BIRTH: D M Y

PERSON TO BE CONTACTED IN CASE OF EMERGENCY HOME #: CELL#:

ALTERNATIVE CONTACT HOME#: CELL#:

FAMILY DOCTOR PHONE #: HEALTH CARD NUMBER

RELEVANT MEDICAL HISTORY:

MEDICATIONS: _____

ALLERGIES: _____

PREVIOUS INJURIES: _____

DOES THE PLAYER CARRY & KNOW HOW TO ADMINISTER HIS / HER OWN MEDICATIONS?

PLEASE CIRCLE: YES NO