PLAYER EMERGENCY INFORMATION

Player's name: _____ Date of Birth: _____ / _____ / _____
(please print) DD MM YY

Parent/guardian's name: _____

Address: _____

_____ Email: _____

Telephone: _____ Cell: _____

IMPORTANT HEALTH INFORMATION

Family doctor: _____ Health Insurance #: _____

Person to contact in case of emergency: _____

Relationship to player: _____ Phone: _____

Any allergies to drugs, if so what? _____

Does player have any other allergies (i.e. bee stings, dust, etc.)? _____

Does player require/carry an EpiPen? _____ Contact Lenses? _____

Does the player suffer from any serious illness (please check):

Asthma _____ Diabetes _____ Epilepsy_____ Other _____

Is the player on any regular medication, if so what? _____

Other relevant information: _____

_____

Signature of parent/guardian: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO THE TEAM MANAGER