



MEDICAL INFORMATION

PLEASE PRINT CLEARLY

Player's Name: _____

Address: _____

Birth date: _____ Age: _____ Gender: _____

Health Card # _____

Doctor: _____ Phone: (_____) _____

Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Parent / Guardian Name: _____

Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Emergency Contact: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Health History

Details:

- | | |
|----------------------------------|------------------|
| Medic Alert | Yes • No • _____ |
| Allergies | Yes • No • _____ |
| Asthma (Respiratory) | Yes • No • _____ |
| Blackouts/Fainting | Yes • No • _____ |
| Diabetes | Yes • No • _____ |
| Epilepsy | Yes • No • _____ |
| Deaf/Hard of Hearing | Yes • No • _____ |
| Heart Condition | Yes • No • _____ |
| Recurring Headaches | Yes • No • _____ |
| Seizures | Yes • No • _____ |
| Glasses | Yes • No • _____ |
| Contact Lenses | Yes • No • _____ |
| Injuries (specify) | Yes • No • _____ |
| Medications (specify) | Yes • No • _____ |
| Other (including recent surgery) | Yes • No • _____ |

Other: _____