EMERGENCY MEDICAL INFORMATION

Name_____
Last First Middle

Address_____

Postal Code_____ Phone Number_____

Date of Birth_____ A.H.C.# _____

Next of Kin _____ Relationship_____

Address, same as above or _____

Phone Number, same as above or _____

Family Doctor _____ Phone Number_____

RELEVANT MEDICAL HISTORY

Medications _____

Allergies (Drugs, Antibiotics) _____

Allergies (Food/Beverage) _____

Previous Injuries _____

Major Operations _____

Contact Lenses: Yes _____ No _____ Type _____

Describe any medical problems that the coaching staff of this team should be aware of. (epilepsy, diabetes, etc.)

_____

_____

_____

_____I

I, THE UNDERSIGNED PARENT (GUARDIAN) HEREBY GIVE MY PERMISSION FOR THE COACH, ASSISTANT COACH, MANAGER OR TRAINER TO AUTHORIZE SUCH EMERGENCY MEDICAL TREATMENT AS MAY BE REQUIRED.

SIGNED _____