PARTICIPANT INFORMATION FORM

Player's Name: ______________________ Date of Birth: ______________

Home Address: ______________________ Phone: ______________

Email: ______________________ Date Form Completed: ______________

Persons To Be Contacted In Case Of Emergency

Mother: ______________________

Phone numbers: Day: ____________ Evening: ____________ Cel: ____________

Father: ______________________

Phone numbers: Day: ____________ Evening: ____________ Cel: ____________

Alternate Contact: ______________________ Relationship to Participant: ______________

Phone numbers: Day: ____________ Evening: ____________ Cel: ____________

Family Doctor: ______________________ Phone: ______________

AHCIP Number: ______________________

Relevant Medical History

Medications: ______________________ Allergies: ______________

Previous Injuries: ______________________

Does the Participant carry and know how to administer his/her own medications? Yes ____ No ____ N/A ____

Has the Participant ever had a concussion? Yes ____ No ____ If so, how many? _____ Date of last concussion: ______________

Other Conditions (braces, contact lenses, etc.) ______________________

Parent's Signature ______________________

Date ______________________