MEDICAL INFORMATION FORM

PLAYER INFORMATION

Player's Name:	Birthdate:
Email:	Cel #:
Home Address:	

PERSONS TO BE CONTACTED IN CASE OF AN EMERGENCY

Person to contact in case of emergency:	
Relationship:	Cel #:
Alternate contact person:	
Relationship:	Cel#:

RELEVANT MEDICAL HISTORY

Family Doctor Name:	Dr. Phone #
Medications:	AB Health #:
Can player administer their own medications:	
Previous Injuries:	
Allergies:	
Has the participant ever had a concussion:	
If so, how many and Date of Last Concussion:	
Other Conditions/Information:	

Parent Signature:	Date: