

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: _____ Cell: _____

Father: _____

Phone numbers: Day: _____ Evening: _____ Cell: _____

Alternate Contact: _____ Relationship to Participant: _____

Phone numbers: Day: _____ Evening: _____ Cell: _____

Family Doctor: _____ Phone: _____

Care Card 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: _____