

PLAYER MEDICAL INFORMATION

Name: _____ Date of Birth: (D) _____ (M) _____ (Y) _____

Person to contact in case of emergency: _____ Ph. (Day) _____

(Evening) _____

Alternate Contact: _____ Ph. (Day) _____

(Evening) _____

Family Doctor: _____ Ph. _____

Health Insurance #: _____ Email: _____

Relevant Medical History

Medications: _____

Allergies: _____

Previous Injuries: _____

Does the player carry and know how to administer his/her own medications? Yes _____ No _____

Other Conditions: _____

Note: Medical information is confidential. Only authorized individuals should have access to this card. Keep this card with the team at all times.