MEDICAL EMERGENCY FORM

PLAYER INFORMATION:

Player Name: _____ Softball BC #: _____

Address: _____ Postal Code: _____

Parents/Guardians: _____

Home Phone: _____ Cell: _____ Work: _____

Email(s): _____

EMERGENCY CONTACT: (Other than parent)

1st Name: _____ Phone: _____ Cell: _____

2nd Name: _____ Phone: _____ Cell: _____

BC Medical #: _____

Doctor's Name: _____ Doctor's Phone: _____

Medical Plan Company: _____ Medical Plan #: _____

Dental Plan Company: _____ Dental Plan #: _____

Please indicate if your player has any medical conditions, health concerns or special needs that we should be aware of:

A) Vision	☐ Glasses	☐ Contacts
B) Hearing	☐ Hearing Aid	
C) Asthma	☐ May Require Treatment	Medication/Type: _____
D) Allergies	☐ May Require Treatment	Medication/Type: _____
E) Epilepsy	☐ May Require Treatment	Medication/Type: _____
F) Diabetes	☐ May Require Treatment	Medication/Type: _____
F) Other	☐ _____	

I, _____ give Langford Minor Fastball permission to obtain emergency treatment for my son/daughter.

Parent/Guardian: _____ Date: _____

Signature: _____ Coach: _____

Pride in today's Youth ⚡ *Faith in tomorrow's Adults*