MEDICAL INFORMATION

PLEASE PRINT CLEARLY

Player's Name: _____

Address: _____

_____

Birthdate: _____ Age:_____ Gender:_____

Health Card # _____

Doctor. _____ Phone: (_____)_____

Address: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell: (____)_____

Parent / Guardian Name:_____

Address: _____

_____

Home Phone: (____)_____ Work Phone: (____)_____ Cell: (____)_____

Emergency Contact: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell: (____)_____

Health History			Details:
Allergies	Yes	No	_____
Asthma (Respiratory)	Yes	No	_____
Blackouts/Fainting	Yes	No	_____
Chest pain	Yes	No	_____
Diabetes	Yes	No	_____
Epilepsy	Yes	No	_____
Hearing Disorder	Yes	No	_____
Heart Condition	Yes	No	_____
Recurring Headaches	Yes	No	_____
Seizures	Yes	No	_____
Glasses	Yes	No	_____
Contact Lenses	Yes	No	_____
Injuries (specify)	Yes	No	_____
Medications (specify)	Yes	No	_____
Other (including recent surgery)	Yes	No	_____

Other:_____