



MEDICAL INFORMATION FORM

All players must have this form on file with the league. Please list all requested information and have a parent/guardian sign.

SECTION I – PERSONAL INFORMATION

Name: _____ DOB: _____ Sex: M ___ F ___

Address: _____ City: _____ Zip: _____

Phone: _____ Emergency Contact Name: _____

Emergency Contact Phone: _____ Emergency Contact Relationship: _____

SECTION II – MEDICAL HISTORY

Are you currently taking any type of prescription or over the counter medication? YES ___ NO ___

If "YES", please list names and dosages: _____

Are you allergic to any type of medication? YES ___ NO ___

If "YES", please list names and dosages: _____

Do you currently have or have had a history of any of the following:

	YES	NO		YES	NO		YES	NO
Allergies			Epilepsy/Seizures			Joint Problems		
Arthritis			Eyeglasses/Contacts			Mononucleosis		
Asthma			Headaches			Nausea/Vomiting		
Back Problems			Hearing Problems			Respiratory Problems		
Bronchitis			Heart Problems			Stomach Problems		
Cancer			Hepatitis (what type)			Surgery (within 3 yrs.)		
Diabetes			Hernia			Vision Problems		
Dizzy/Fainting			High/Low Blood Pressure			Other Not Listed		

If "YES" to any of the above, please explain. _____

SECTION III – CONSENT TO MEDICAL TREATMENT

If the above named participant needs emergency medical treatment and the emergency contact cannot be reached, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the team/league personnel.

Signature of Parent/Guardian

Print Name

Date