Health Form

Player: _____ Date of Birth: _____

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: Phone: _____

Address: _____

Hospital Preference: _____

In case of emergency contact:

Name /Phone/Relationship to Player_____

Name/Phone/Relationship to Player_____

Please list any allergies/medical problems, including those requiring maintenance medications. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Allergies and Action Plan_____

_____

(Action plan needs to be given to the counselors)

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem, which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: _____

Mr./Mrs./Ms. Authorized Parent/Guardian Signature

_____