West Hill Softball Player Medical Information Form

TEAM NAME AND DIVISION	
EMERGENCY MEDICAL INFORMATION	
PLAYER NAME	
ADDRESS	
POSTAL CODE	
PHONE NUMBER	
DATE OF BIRTH	
AHC #	
ADDITIONAL MEDICAL COVERAGE (Y/N)	
EMERGENCY CONTACT(S)	
RELATIONSHIP	
ADDRESS	
PHONE NUMBER	
FAMILY DOCTOR	
PHONE NUMBER	
RELEVANT MEDICAL HISTORY	
MEDICATIONS	
ALLERGIES (DRUGS, ANTIBIOTICS)	
ALLERGIES (FOOD/BEVERAGE)	
DATE OF LAST TETANUS SHOT	
PREVIOUS INJURIES	
MAJOR OPERATIONS	
CONTACT LENSES: (Y/N)	
If yes, type of lenses:	
DESCRIBE ANY MEDICAL PROBLEMS THAT THE COACHING STAFF SHOULD BE AWARE OF, E.G. EPILEPSY, DIABETES, MONONUCLEOSIS, ETC	
I, THE UNDERSIGNED PARENT (GUARDIAN) HEREBY GIVE MY PERMISSION FOR THE COACH, ASSISTANT COACH, MANAGER, PARENT TO AUTHORIZE SUCH EMERGENCY MEDICAL TREATMENT AS MAY BE REQUIRED	
NAME (PLEASE PRINT)	
SIGNED	
DATE	