

Player Emergency Information Form

Player Name: _____ Date of Birth: _____

Address: _____

Home Phone #: _____ Email: _____

Primary Emergency Contact:

Name: _____ Relationship: _____

Cell #: _____ Email: _____

Alternate Emergency Contact:

Name: _____ Relationship: _____

Cell #: _____ Email: _____

Doctor Contact:

Family Doctor: _____ Phone #: _____

Medical Information

Is the player allergic to medications? Yes No

If so, please list: _____

Does the player have other allergies? Yes No

If so, please list: _____

Does the player take any regular medication(s)? Yes No

If so, please list: _____

Does the player wear contact lenses? Yes No

Please list previous injuries/concussions (include dates): _____

Does the player suffer from any serious illnesses or conditions (check below)?

Asthma

Diabetes

Epilepsy

Other (please specify): _____

Signature: _____

Print Name: _____

Date: _____