



PARTICIPANT INFORMATION FORM

Player's Name: _____ Date of Birth: _____

Home Address: _____ Phone: _____

Email: _____ Date Form Completed: _____

Persons To Be Contacted In Case Of Emergency

Mother: _____

Phone numbers: Day: _____ Evening: _____ Cel: _____

Father: _____

Phone numbers: Day: _____ Evening: _____ Cel: _____

Alternate Contact: _____ Relationship to Participant: _____

Phone numbers: Day: _____ Evening: _____ Cel: _____

Family Doctor: _____ Phone: _____

CareCard Number: _____

Relevant Medical History

Medications: _____ Allergies: _____

Previous Injuries: _____

Does the Participant carry and know how to administer his/her own medications? Yes ___ No ___ N/A ___

Has the Participant ever had a concussion? Yes ___ No ___ If so, how many? _____ Date of last concussion: _____

Other Conditions (braces, contact lenses, etc.) _____

Note: Medical information is confidential.

This card will be kept with the team at all times and will not be available to other than authorized individuals (Coaches, Manager, Trainers)

Parent's Signature _____

Date _____