

Player Medical History

All information is strictly confidential; this form is to be brought to each game and practice by the team manager for emergency use only.

Players Name		
Address		
Age:	Sex:	Birthday:
Medical Insurance No.		
Parents/Guardians Name		
Home No.		
Alternate Contact:		
Do you require corrective lenses?		
Record of illness, Check those that have occurred at any time.		
Asthma	Heart Disease	
Diabetes		
State illnesses of past five years:		
Injuries (specify):		
Other illnesses or surgery:		
Check if you suffer from any of the following:		
Recurring headache	Blackout	
Seizures	Chest pain	
Physicians name:		
Phone Number		
Immunisation year of last tetanus shot?		
List allergies and/or regular medication:		
Date card completed		
Date updated		