YOUTH ATHLETICS EMERGENCY INFORMATION

PLEASE RETURN TO YOUR COACH AT YOUR FIRST SCHEDULED PRACTICE

PLAYER NAME:______________________________PARENT NAME:___________________________

ADDRESS:____

CITY:__________________________________STATE_______ZIP:________________________________

HOME #:(___)_______________ WORK #: (___)_________________CELL #: (___)________________

D.O.B:__________________ AGE:___________ GRADE _____________SCHOOL: ________________

EMERGENCY CONTACT PERSON(S): ____

EMERGENCY PHONE NUMBERS: (_____)__________________ (_____)______________________

PHYSICIANS NAME: _______________________________PHONE #: (_____)____________________

OPTIONAL MEDICAL HISTORY:

- ☐ Asthma
- ☐ Surgery within the year
- ☐ Bleeding tendencies
- ☐ Head injuries within the year
- ☐ Seizures or fits
- ☐ Dental braces or bridges
- ☐ Current medication
- ☐ Glasses or contacts
- ☐ Allergies
- ☐ Serious illness
- ☐ Diabetes
- ☐ Fractures within the year
- ☐ Heart murmur
- ☐ Other

Other: ____

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