THIS FORM MUST BE AVAILABLE AT ALL BASKETBALL ACTIVITIES

Player Medical Information Form

(must be completed by parent or guardian)

Player's Name: ____

Parent/Guardian's Name: ____________________________________ Phone: ____________

Address: ____ Work Phone: __________

Cell Phone: ___________

Person, other than parent, to notify in case of emergency:

Name: ____ Phone: ____________

Cell Phone: ___________

Family Physician: ____ Phone:

Address:____

Medical Insurance: ___________________________ Policy #: ________________________

Hospital Preference: ____

The player has or is subject to (check if yes):

☐ Asthma ☐ Fainting Spells ☐ Convulsions ☐ Diabetes ☐Arthritis

☐ Heart Trouble ☐ Allergy or Reaction to ANY Medication, Insect Bites/Stings, Food

☐ Sports Restrictions (please list):

☐ Other (please describe):

Difficulty with (check if yes):

☐ Eyes, Ears, Nose, Throat ☐ Digestion ☐ Menstrual Problems ☐ Lungs

☐ Any condition now requiring medication? Name of Medication: _______________________

Reason for medication: ____

☐ Any restriction of activity for medical reasons?

Explain: ____

____

Signature of Parent/Guardian: ________________________________ Date: ____________

Signature of Player: ______________________________________ Date: ____________