



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 _____