



Medical Information Form

Player's Name	Date:
Address	Postal Code
Phone #	Health Card Number
Parent/Guardian	Work Phone #
Player's Physician	Phone #
Emergency Contact Name	Phone #

Medical Information:

1. Date of Last complete medical examination: _____
2. Date of last tetanus immunization: _____
3. Is your son/daughter/ward allergic to any drugs, foods or medication/other? Yes ___ No ___ If yes provide details: _____
4. Does your son/daughter/ward take any prescription drugs? Yes ___ No ___ If yes, provide details: _____
5. What medication(s) should the participant have on hand during volleyball? _____
Who should administer the medication? _____
6. Does your son/daughter/ward wear a medical alert bracelet _____, neck chain _____ or carry a medical alert card? Yes ___ No ___
Please indicate if your son/daughter/ward has been subject to any of the following and provide pertinent details:
Epilepsy, diabetes, orthopedic problems, deaf/hard of hearing, asthma, allergies _____
Head or back conditions or injuries (in the past two years) _____
7. Arthritis or rheumatism, chronic nosebleeds, dizziness, hernia, swollen, hyper mobile or painful joints, trick or lock knee: _____
8. Any other medical information that will limit participation? _____
9. Should your son/daughter/ward sustain an injury or contract an illness requiring medical attention during the competitive season, notify the coach.

MEDICAL SERVICES AUTHORIZATION

In case of emergency medical or hospital services being required by the above listed participant, and with the understanding that every reasonable effort will be made by the Club to contact me, my signature on this form authorizes medical personnel and/or hospital to administer medical and/or surgical services including anesthesia and drugs. I understand that any cost will be my responsibility.

SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____