



PLAYER MEDICAL INFORMATION FORM

Confidential – For Player Safety and Emergencies Only

PLAYER INFORMATION

Name: _____ DOB (DD/MM/YYYY): _____ Age: ____

PARENT / GUARDIAN CONTACTS

Primary Contact

Name: _____ Cell: _____ Work/Home: _____

Email: _____

Secondary Contact (if applicable)

Name: _____ Cell: _____

EMERGENCY CONTACT (if parent/guardian unavailable)

Name: _____ Relationship: _____ Phone: _____

MEDICAL INFORMATION (check and add details if yes)

Medical Conditions (asthma, diabetes, seizures, heart, etc.)

No Yes → _____

Allergies (food, medication, insect stings, other) No Yes → _____

Concussion History No Yes → _____

Injuries / Surgeries (past 12 months) No Yes → _____

MEDICATION & EMERGENCY CARE

May coaches give Tylenol / Advil? Yes No

Asthma Inhaler required? Yes No EpiPen required? Yes No

Location of inhaler / EpiPen: _____

May coaches assist? Yes No

Special Instructions:

CONSENT & AUTHORIZATION

I authorize coaches, team officials, and volunteers to obtain emergency medical treatment for my child if I cannot be reached. I confirm the above information is accurate.

Parent/Guardian Name (Print): _____ Signature: _____ Date: _____