Medical Information Form

Athlete's Name:	Date of Birth(dd/mm/yy):
Address:	Parent(s)/Guardian(s):
Postal Code:	Parent/Guardian Cell Phone:
Home Phone:	Parent/Guardian Cell Phone:
Athlete Cell Phone:	Parent/GuardianWork Phone:
Athlete's Physician:	Parent/Guardian Work Phone:
Emergency Contact Name:	Emergency Contact 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 __
7. Please indicate if your son/daughter/ward has been subject to any of the following and provide pertinent details:
   Concussion, epilepsy, diabetes, orthopedic problems, heart conditions, deaf/hard of hearing, asthma, seasonal allergies _____________
   ____
8. Any other medical condition that will limit participation? ____
9. Should your son/daughter/ward sustain an injury or contract an illness requiring medical attention during the competitive season please notify the coach and or team manager.

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 staff to administer medical and/or surgical services including anesthesia and drugs to my child/ward. I understand that any cost will be my responsibility.

SIGNATURE OF PARENT/GUARDIAN ____________________________________ DATE: __________