

YWCA GIRLS COMMUNITY FIELD HOCKEY PROGRAM
Medical History/Emergency Contact Form

Athletes
Name _____ Age _____ Birthdate _____
Parents Name _____

Health History

Do you have any injuries requiring medical attention or have you had surgery in the 12 months? Yes No

If YES, Please describe _____

Do you have any known allergies? Yes No

If Yes, Please describe _____

Are you under a physician's care or taking medication? Yes No
Please explain _____

Do you wear contacts? Yes No

When was the date of your last tetanus booster? _____

Have you ever been dizzy or passed out during or after exercise? Yes No

Have you ever had blackouts, seizures or a concussion? Yes No

Special Disabilities (if any) _____

Allergies (including medication reaction) _____

Medical or Dietary Information Necessary in an Emergency Situation _____

Medication, Special Conditions _____

Additional Information on Special Needs of Child _____

In case of emergency, parents can be reached at the following numbers:

Number _____ Number _____

In case parents cannot be contacted please call:

Contact Name _____ Number _____

Contact Name _____ Number _____

Medical Insurance Information

Signed: _____ (print name) _____

Emergency Contact Phone or Cell _____

Health Insurance Coverage:

Agreement No _____ Group No _____

Subscriber No _____

Carrier _____

Identification Nos _____

Doctor's Name and Phone _____