



MEDICAL EMERGENCY & HEALTH HISTORY INFO



Use This Form for Same Family Members Only and Please Print Clearly

Player 1

Participant's Name: _____

Birthdate: _____ Sex: ____ Weight: _____ Height: _____

Mother's Name: _____

Day #: _____ Pager/Mobile #: _____

Father's Name: _____

Day #: _____ Pager/Mobile #: _____

If above is not available in an emergency, please contact:

Name: _____

Day #: _____ Pager/Mobile #: _____

Participant's Physician: _____

Day #: _____ Pager/Mobile #: _____

Medical Insurance Co.: _____

Insurance/Policy #: _____

Health History Information

Convulsions/Seizures: _____ Diabetes: _____ Nosebleeds: _____
Epilepsy: _____ Skin Cancer: _____ Other: _____

If yes to any of these or other, please specify: _____

Hay Fever: _____ Asthma: _____ Bee/wasp Stings: _____ Other: _____

If yes to any of these allergies or other, please specify: _____

Date of last tetanus booster: _____

Special Diet: _____

Medications to be administered at camp: _____

Is your child under the care of a physician? If yes, please detail);

Does participant have any special needs or conditions that staff should be aware of? (Staple attachment if needed): _____

Player 2

Participant's Name: _____

Birthdate: _____ Sex: ____ Weight: _____ Height: _____

Mother's Name: _____

Day #: _____ Pager/Mobile #: _____

Father's Name: _____

Day #: _____ Pager/Mobile #: _____

If above is not available in an emergency, please contact:

Name: _____

Day #: _____ Pager/Mobile #: _____

Participant's Physician: _____

Day #: _____ Pager/Mobile #: _____

Medical Insurance Co.: _____

Insurance/Policy #: _____

Health History Information

Convulsions/Seizures: _____ Diabetes: _____ Nosebleeds: _____
Epilepsy: _____ Skin Cancer: _____ Other: _____

If yes to any of these or other, please specify: _____

Hay Fever: _____ Asthma: _____ Bee/wasp Stings: _____ Other: _____

If yes to any of these allergies or other, please specify: _____

Date of last tetanus booster: _____

Special Diet: _____

Medications to be administered at camp: _____

Is your child under the care of a physician? If yes, please detail);

Does participant have any special needs or conditions that staff should be aware of? (Staple attachment if needed): _____

***Please remember to complete and attach Registration & General Release & Liability Waiver form!**