



## PARTICIPANT INFORMATION FORM

**Player's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Date Form Completed:** \_\_\_\_\_

### Persons To Be Contacted In Case Of Emergency

**Mother:** \_\_\_\_\_  
**Phone numbers:** Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cel: \_\_\_\_\_  
**Father:** \_\_\_\_\_  
**Phone numbers:** Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cel: \_\_\_\_\_  
**Alternate Contact:** \_\_\_\_\_ **Relationship to Participant:** \_\_\_\_\_  
**Phone numbers:** Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cel: \_\_\_\_\_  
**Family Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**CareCard Number:** \_\_\_\_\_

### Relevant Medical History

**Medications:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_  
**Previous Injuries:** \_\_\_\_\_  
Does the Participant carry and know how to administer his/her own medications? Yes \_\_\_ No \_\_\_ N/A \_\_\_  
Has the Participant ever had a concussion? Yes \_\_\_ No \_\_\_ If so, how many? \_\_\_\_\_ Date of last concussion: \_\_\_\_\_  
**Other Conditions (braces, contact lenses, etc.)** \_\_\_\_\_

*Note: Medical information is confidential.*

*This card will be kept with the team at all times and will not be available to other than authorized individuals (Coaches, Manager, Trainers)*

**Parent's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_