

# APPENDIX D

## EMERGENCY/MEDICAL FORM

Name \_\_\_\_\_ Home Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father \_\_\_\_\_ Telephone (w) \_\_\_\_\_ (h) \_\_\_\_\_

Mother \_\_\_\_\_ Telephone (w) \_\_\_\_\_ (h) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone (w) \_\_\_\_\_ (h) \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Physician Address \_\_\_\_\_

Preferred place of medical treatment \_\_\_\_\_

Please list history of any previous injuries, operations, etc. \_\_\_\_\_

\_\_\_\_\_

Special medical conditions, allergies, etc. \_\_\_\_\_

\_\_\_\_\_

Is the athlete on any special medication \_\_\_\_\_

\_\_\_\_\_

Is the athlete limited in his/her athletic participation. Please explain \_\_\_\_\_

\_\_\_\_\_

Any other special restrictions \_\_\_\_\_

\_\_\_\_\_

Other special remarks, instructions, etc. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_