

YWCA GIRLS COMMUNITY FIELD HOCKEY LEAGUE

MEDICAL HISTORY 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

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 Information

Name of Child's Physician/Medical Care Provider _____

Address _____ Phone _____

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 _____

Health Insurance Coverage for Child or Medical Assistance Benefits _____

Policy Number (required) _____