PLAYER MEDICAL INFORMATION SHEET

UXBRIDGE YOUTH BASEBALL ASSOCIATION

Player's
Name_____
Date of Birth: Day _____Month _____Year _____
Address: _____
City: _____ Postal Code: _____ Phone: _____
Mother's Name: _____Father's Name: _____
Work Phone - Mother: _____ Work Phone - Father: _____

Person to contact in case of accident or emergency, if parents are not available:

Name: _____ Telephone: _____
Address: _____
Family Doctor: _____ Telephone: _____
Family Dentist: _____ Telephone: _____

Please check the appropriate responses that pertain to your child.

Description	Yes	No	Description	Yes	No
History of concussions			History of Asthma		
History of fainting spells			Wear Medic Bracelet/Necklace		
History of epilepsy			Diabetes		
Wear dental appliances			Hearing Problems		
Presently Injured			Surgery in the last year		
Wears Glasses/Contacts			Are they shatterproof?		
Allergies			Medications		

Please give details if you answered YES to any of the above items

I understand that it is my responsibility to keep the team management advised of any changes in the above information as soon as possible and that in the event no one can be contacted, the team management has the authority to take my child to a hospital/medical facility if deemed necessary.
I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize the release of all information in this form only to relevant medical personnel, as well as information being supplied to the management team as deemed necessary.

Date: Parent/Guardian: