MEDICAL INFORMATION FORM

Surname_____Given Names_____

Date of Birth_____B.C. Care Card Number_____

Contact Person(s) in event of emergency:_____
(Parent/Guardian)
Day Phone:_____
Evening Phone:_____
Other (Cell):_____

Contact Person if there is no answer at the above numbers:
_____

Day Phone:_____
Evening Phone:_____

Family Doctor: Name:_____
Phone:_____
Address:_____
_____

Please give relevant medical information with respect to:

Medications: _____
_____
Are they carried by your child?_____
Are they administered by your child?_____

Allergies:_____

Previous Injuries: _____
_____
_____

Is there anything else we should know? _____
_____
_____
_____
In the event that my child requires immediate medical treatment, I hereby authorize the leaque officials to seek such treatment:

_____ _____
Signature of Parent or Guardian Date
I consent to this form being kept in the Umpire Change Room so it can be accessed for medical emergencies.