Player Insurance & Medical Information Sheet:

EACH PARTICIPANT IS REQUIRED TO BE COVERED BY MEDICAL/HOSPITAL INSURANCE

Participant Name: _____

Insured Name: _____

Relationship to Participant:_____

Insured Address: _____

Insurance Company Carrier or Plan Name Group Number:_____

Insurance ID Number _____

PARTICIPANT HEALTH HISTORY

ALLERGIES:

Medication _____

Food /Other _____

MEDICATIONS TAKEN (on regular basis):

Prescription (please include dosage and times taken) _____

Nonprescription (please include dosage and times taken) _____

DIETARY RESTRICTIONS: _____

TO BE SIGNED BY PARENT OR GUARDIAN

I certify that the above information is complete and accurate to the best of my knowledge.

PARENT/GUARDIAN (Please print): _____

DATE SIGNED: _____