



**BURLINGTON BAYHAWKS
Player Emergency Information Form**

Players Name: _____ DOB: _____

Address: _____

Phone #: _____

Emergency Contacts

Mother/Guardian: _____ Father/Guardian: _____

Phone #: _____ Phone #: _____

Cell #: _____ Cell #: _____

Alternate Contact(s)

Name: _____ Relationship: _____

Phone #: _____ Cell #: _____

Family Doctor: _____ Phone #: _____

Medical Information

**This information is being provided voluntarily in accordance with the BYSC Privacy Policy.

Is player allergic to medications? If so, please list.

Does player have other allergies (i.e. bee sting, food, environmental, etc.)? If so, please list.

Does player suffer from any serious illnesses? (Please check)

Asthma Diabetes Epilepsy Other (please specify) _____

Does player take any regular medication(s)? If so, please list.

Does player wear contact lenses, glasses? _____

Does player have previous injuries / concussions (please include date(s):

Signature: _____

Date Signed: _____