

**RAIN CITY FLYERS
MEDICAL INFORMATION AND EMERGENCY CONSENT**

Athlete's Name: _____ Date of Birth: _____

Address: _____

Parent/Legal Guardian: _____

Day Telephone: _____ Evening phone: _____

E-Mail: _____

Physician Name: _____

Office phone: _____ Emergency Phone: _____

Medical Insurance Plan: _____

Policy Number: _____

SIGNIFICANT MEDICAL INFORMATION:

- | | | |
|---|-----|----|
| 1. Are there any limitations on your ability to participate in strenuous physical activity? | Yes | No |
| 2. Are you currently suffering from or limited by physical injury or medical condition? | Yes | No |
| 3. Have you suffered any significant physical injuries in the past year? | Yes | No |
| 4. Do you have any allergies? | Yes | No |
| 5. Are you currently taking any prescription medication? | Yes | No |

If you answer "Yes" to any of the above questions, please explain below:

EMERGENCY MEDICAL TREATMENT CONSENT

I the undersigned parent/legal guardian of _____, consent to the performance of such emergency care upon his/her person as may be deemed necessary or advisable in the judgement of the examining physician or emergency medical responder, in the event I cannot be contacted at the time of an emergency.

Parent/Legal Guardian Signature: _____ Date _____