



PLAYER MEDICAL INFORMATION FORM
INNISFIL MINOR BASEBALL ASSOCIATION

PLAYER INFORMATION:				
Players Name		Health Card # (Optional)		
Date of Birth		Player Telephone # (if applicable)		
Address				
EMERGENCY CONTACT INFORMATION:				
Parent/Guardian Name		Contact #		
Parent/Guardian Name		Contact #		
Emergency Contact if Parent/Guardian is not available				
Name & Relationship		Contact #		
MEDICAL INFORMATION:				
Doctor's Name		Contact #		
Dentist's Name		Contact #		
PLEASE CHECK THE APPROPRIATE BOXES AS THEY APPLY			YES	NO
History of Concussions				
History of Fainting				
If Either Provide details:				
Epileptic				
Wears glasses (shatterproof) or contacts lenses				
Wears dental application				
Asthmatic or has history of breathing trouble during exercise				
Medic Alert Worn				
If Yes, condition:				
Diabetic (Type I or II)				
Medicals that affect your child's ability to play baseball				
If yes, please provide:				
Hearing Impairments				
Allergies				
If yes, please provide:				
Any other pertinent information please specify:				

By Signing this document I agree that a) it is my responsibility to update this form as I become aware of changes to my child's health; b) that in the event of a medical emergency I give my permission for team management to seek medical attention for my child if the above persons' cannot be reached, including providing transportation to a medical facility and I consent to having this medical information provided to medical personnel; and c) I acknowledge that I have read and understood the content provided to me by the league related to Rowan's Law and OBA Concussion Protocol me and my child's coaching staff are bound by.

Signature:	Date:
------------	-------