Fernie Volleyball Club Athlete Medical Information

Last Name: _____ First Name: _____
Date of Birth (Day/Month/Year):_____ Male: ☐ Female: ☐
Home Phone: _____ Cell Phone: _____
Care Card Personal Health #: _____
Family Doctor: _____ Phone: _____

Parent/Guardian Information:
Last Name: _____ First Name: _____
Relationship to Participant: _____
Email Address:_____Cell Phone: _____
Home Phone: _____ Work Phone: _____

Parent/Guardian (Alternative Contact) Information:
Last Name:_____ First Name:_____
Relationship to Participant:_____
Email Address: _____ Cell Phone: _____
Home Phone:_____ Work Phone:_____

Alternate Emergency Contact (1)
Name:_____ Phone:_____
Relationship to Athlete:_____

Medical Information
Please note any health conditions, physical handicap, emotional difficulty, or other factors that may limit full participation in this program. _____
_____
Has the athlete had a previous injury that would require special first aid treatment should another injury occur?_____

Athlete is subject to: (Please Check All that Apply)

Asthma	☐	Sinus Problems	☐	Dislocations	☐	Dizziness	☐	Ear ache	☐		
Sprains	☐	Eye infections	☐	Fainting	☐	Frequent Colds	☐	Headaches	☐		
Kidney problems	☐	Motion Sickness	☐	Muscle Pulls	☐	Nose bleeds	☐	Seizures	☐		
Sensitive Skin	☐	Allergies (Describe)	☐	High Blood Pressure	☐						

Concussions (Dates/Length of Recovery): _____
Other conditions and/or *further detail (describe below or on back of page)
_____
_____

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.
Parent/Guardian Signature:_____Date: _____