

Warrior Select Basketball
Medical Information and Authorization

Player Name: _____

Birth Date: _____

Address: _____

Grade: _____

Allergies and drug reactions: _____

Chronic illness: _____

Regular medications: _____

Date of last tetanus immunization: _____

Medical or physical limitations: _____

Child's Physician: _____

Phone: _____

Emergency Contact 1: _____

Phone: _____

Emergency Contact 2: _____

Phone: _____

Parent/Guardian: _____

Parent/Guardian: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

email: _____

email: _____

Medical Insurance Co. _____

Policy Number: _____

I/we, the parent/legal guardian of _____, authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by health care professionals immediately necessary and advisable in the interest of my child's health and well-being. I/we authorize the Warrior Select Basketball Club, its coaches and representatives, to seek immediate medical care for my child if deemed necessary and appropriate in the event of my/our absence.

Signature (parent/legal guardian)

Signature (parent/legal guardian)

date

date