Emergency Medical Information
Confidential

Player Name: ____

Date of Birth: ____

BC Medical Number: ____

Family Doctor: __________________________ Phone: _______________

Family Dentist: _________________________ Phone: _______________

Father: ________________________________

Home Phone: ___________Bus Phone: ___________ Cell Phone: ___________

Mother: ________________________________

Home Phone: ____________Bus Phone: ___________Cell Phone: __________

Alternate Contact: ____

Relation to athlete: ____

Home Phone: ____________Bus Phone: ___________Cell Phone: __________

Medications: ____

Allergies: ____

Previous Injuries: ____

Does the athlete carry and know how to administer their medication?

YES ________ NO ________

Other conditions (braces, eye glasses, etc…) _____________________________

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Permission To Authorize Treatment

I/We____

____

As the parents/guardians of

____(Athlete)

Designate and authorize the coaching staff of Youth Ringette, specifically:

COACH: ____

ASSISSTANT: ____

ASSISSTANT: ____

MANAGER: ____

to act as our proxies in the event that our son/daughter, forenamed, requires immediate medical treatment, and we are not present or able to authorize the required treatment.

Specifically exempting the following: ___________________________________

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____

Signed at ______________________________ this ____________ day of _____

Witness: __________________________Parent: ________________________

Witness: __________________________Parent: ________________________