NORTHUMBERLAND

BASEBALL ASSOCIATION

Medical Information Sheet

Name:	
Date of Birth: Month/ Day/ Year	
Address:	
Postal Code:	Telephone:
Mother:	Cell Number:
Father:	Cell Number:

Alternate Emergency Contact (if parents are not available)

Name:	Telephone:
Address:	
Doctor's Name:	Telephone:
Dentist's Name:	Telephone:
Date of last complete physical Examination:	

*Before a player participates in a baseball program, any medical condition or injury problems should be checked by that individual's family physician.

Please circle the appropriate response and provide details below if you answer "YES" to any of the questions.

Yes	No	Previous history of concussions	Yes	No	Hearing impaired
Yes	No	Fainting episodes during exercise	Yes	No	Asthma
Yes	No	Epileptic	Yes	No	Trouble breathing during exercise
Yes	No	Wears glasses	Yes	No	Heart condition
Yes	No	Are lenses shatterproof	Yes	No	Diabetic Type 1/Type 2
Yes	No	Wears dental appliance	Yes	No	Medication
Yes	No	Allergies			

Yes No	Wears a medical information necklace/bracelet.
Yes No	Has any health problem that would interfere with participation on a baseball team
Yes No	Has had an illness that lasted more than a week and required medical attention in the past year
Yes No	Has had injuries requiring medical attention in the past year
Yes No	Has been admitted to hospital in the last year
Yes No	Surgery in the last year
Yes No	Presently injured
Yes No	Vaccinations up to date Last tetanus shot:
Yes No	Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above.

Medications:
Allergies:
Medical Conditions:
Recent Injuries:
Any information not covered above:

I understand that it is my responsibility to keep the Head Coach advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.

I authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Parent or Guardian: _____