

2010 Seymour Pop Warner
Emergency Medical Form

TEAM: _____ COACH: _____
LAST NAME: _____ FIRST NAME: _____
ADDRESS: _____
TOWN: _____ ZIP: _____
AGE: _____ DOB: _____

PARENT/GUARDIAN: _____
HOME PHONE: _____ CELL PHONE: _____
WORK PHONE: _____ PAGER: _____

EMERGENCY CONTACT: (IF PARENT OR GUARDIAN UNABLE TO BE REACHED)
FIRST CHOICE: _____
NAME: _____ PHONE: _____
SECOND CHOICE: _____
NAME: _____ PHONE: _____

MEDICAL INSURANCE PLAN: _____
POLICY#: _____ GROUP#: _____
PEDIATRICIAN: _____ ADDRESS: _____
PHONE: _____
HOSPITAL CHOICE: _____

LIST ANY PAST MEDICAL ILLNESSES:

LIST ANY ALLERGIES (INCLUDE BEE STINGS, FOODS, MEDS):

LIST ANY ILLNESSES CURRENTLY BEING TREATED:

LIST CURRENT MEDICATIONS (DOSAGES AND HOW OFTEN):

PARENTS: IT IS ESSENTIAL THAT ONE PARENT/GUARDIAN ATTEND ALL PRACTICES/GAMES. COACHES/MEDICS ARE NOT LICENSED TO DISPENSE MEDICATIONS TO YOUR CHLD!! If your child is independent in the use of any medications, i.e. inhalers, epi pens we need a doctors release for child to self administer.
Please sign and date that you understand and agree to above:

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
REVIEWED BY MEDICAL DIRECTOR: _____ DATE: _____