

**APPENDIX B | PLAYER MEDICAL HISTORY FORM TEMPLATE**

**PLAYER INFORMATION**

<b>Legal Name:</b>		<b>Derby Name:</b>	
<b>Date of Birth:</b>		<b>Today's Date:</b>	

**PARENT / GUARDIAN & EMERGENCY CONTACT INFORMATION**

<b>Parent / Guardian 1</b>	<i>Legal Name</i>	
	<i>Phone Number(s)</i>	
	<i>Address</i>	
<b>Parent / Guardian 2</b>	<i>Legal Name</i>	
	<i>Phone Number(s)</i>	
	<i>Address</i>	
<b>Primary Emergency Contact</b>	<i>Legal Name</i>	
	<i>Phone Number(s)</i>	
<b>Doctor / Clinic &amp; Insurance</b> <i>Note: Attach a copy of primary insurance card (front &amp; back)</i>	<i>Name (Doctor / clinic)</i>	
	<i>Phone Number</i>	
	<i>Insurance Provider</i>	

**MEDICATION LIST** (List any medications taken regularly by the player. Mark all scheduled dosage times that apply).

<b>Medication Name</b>	<b>Dosage / Instructions</b>	<b>AM</b>	<b>MID</b>	<b>PM</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Does the Player have...</b>	<b>No</b>	<b>Yes</b>	<b>Does the Player have...</b>	<b>No</b>	<b>Yes</b>
Attention Deficit Hyperactivity Disorder			Diabetes?		
Allergies? (List below)			Emotional Concerns?		
Anaphylactic Allergy?			Epilepsy Seizures?		
Anemia?			Hearing Impairment?		
Asthma? If yes, <b>circle one:</b> <b>Mild   Moderate   Severe</b>			Heart Problems?		
Bladder Problems?			Vision Impairment?		
Bowel Problems?			<b>Contacts</b> or <b>Glasses</b> (If yes, circle applicable)		
Dental Problems?			Had a serious injury?		
Depression or Anxiety? <b>Circle one.</b>			Any other health (physical, mental, emotional) conditions? (Explain below)		

**NOTE:** If the answer to any of the above is YES, explain on the next page (continue on a separate sheet and attach to this form if needed).

<b>Further explanation for any YES marked above:</b>
<b>For any YES marked above, has the player ever been hospitalized or visited the Emergency Room for this condition? Please explain:</b>
<b>List ALL known allergies:</b>
<b>If the skater has severe allergies, does the skater require an EpiPen be carried on his or her person at all times? If yes, where is it located?</b>
<b>Any additional comments / pertinent health information:</b>

<b>ACKNOWLEDGEMENTS</b>			
<p>The team ( <span style="background-color: yellow; border: 1px solid black; display: inline-block; width: 150px; height: 1em; vertical-align: middle;"></span> / JRDA) may determine, at their discretion, if it is a safety risk for your child to participate in team and / or league activities.</p> <p>The provided medical information is correct to the best of my knowledge. I understand that it is my responsibility to update this information when the skater’s medical history or medical insurance changes.</p>			
<b>Parent / Guardian Name:</b>		<b>Signature:</b>	
<b>Date:</b>			

