Bath Charter Township
PARKS & RECREATION
EMERGENCY MEDICAL FORM

PLAYER'S NAME: _____ BIRTH DATE: _____

ADDRESS: _____
STREET CITY ZIP

HOME PHONE: _____ PARENT CELL: _____

PARENT E-MAIL:_____

History of Concussions? _____ If yes, please explain duration & cause_____
_____

IN CASE OF AN EMERGENCY CONTACT:

_____ _____
NAME HOME PHONE

_____ _____
RELATIONSHIP WORK PHONE

OR

_____ _____
NAME HOME PHONE

_____ _____
RELATIONSHIP WORK PHONE

PHYSICIAN'S NAME: _____ _____
PHONE

MEDICAL INSURER _____ _____
PHONE

IN THE EVENT OF A MEDICAL EMERGENCY, PLEASE INDICATE WHAT ACTION YOU WISH TAKEN IN WHAT ORDER:
_____

_____

DO YOU HAVE A PREFERENCE OF HOSPITALS?_____

KNOWN ALLERGIES, MEDICATIONS, MEDICAL CONDITIONS, PREVIOUS CONCUSSIONS, OR ANY OTHER PERTINENT INFORMATION ABOUT YOUR CHILD:
_____

_____

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE