Medical History & Emergency Contact / Authorization Form

Participant Information

Player Name: _____	DOB: _____
Grade: _____	Age: _____
Parent/Guardian: _____	Phone: _____
Address: _____	

Emergency Contacts

Primary Contact	Relationship	Phone
_____	_____	_____
Secondary Contact	Relationship	Phone
_____	_____	_____

Medical History

Primary Physician: _____ Phone: _____
Hospital Preference: _____
Insurance Provider: _____ Policy #: _____

Allergies: _____
Current Medications: _____
Medical Conditions (Asthma, Diabetes, Seizures, Cardiac, etc.):
_____
Previous Concussion(s): Yes / No Date(s): _____
Activity Restrictions or Special Instructions: _____

Emergency Authorization

I certify the information above is accurate to the best of my knowledge. I authorize the Washington Panthers Youth Football Program, its coaches, volunteers, athletic trainers, and emergency medical personnel to obtain emergency medical treatment for my child if I cannot be reached. I understand every reasonable effort will be made to contact me first and I accept financial responsibility for medical care provided. I agree to immediately notify the Program of any changes to my child's medical condition during the season.

Parent/Guardian Signature: _____ Date: _____