

Medical Information and Waiver

Coach's Information:

Name: _____
Last First MI

Sex: M or F Birthdate: ____/____/____

Cell Phone: _____

Address: _____
Street City/State Zip

PLEASE LIST ANY MEDICATION YOU ARE TAKING OR TAKE ROUTINELY

DO YOU HAVE A HISTORY OF ANY ALLERGIES? (ie: medications, bee stings, food, environment)

Emergency Contacts:

Who should be contacted in case of an emergency?

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Health Insurance Information:

Are you covered by health insurance? Yes No

By which Company? _____

Guarantor's name _____ Relationship: _____

Address/City/State/Zip: _____

Policy # _____ Group # _____

Guarantor's Social Security #: _____

Primary Ins. Co. _____

PLEASE ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD.

Signature of Coach or Guardian Date

Printed Name