



Medical Information Card

Name: _____ Team: _____

Date of Birth: _____ Sex: M F

Address: _____

Street

City

State

Zip Code

Parent/Guardian Name (s): _____

Home Phone #: _____ Cell Phone # _____ Work Phone # _____

Medical Conditions or Problems: _____

Current Medications: _____

Allergies: _____

Family Doctor: _____ Doctor Phone# _____

Preferred Hospital: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____ Alternate Phone#: _____

Medical Insurance Carrier: _____

Identification # _____

Name of Insured: _____

Parent/Guardian Signature: _____ Date: _____