

PARTICIPANT INFORMATION CARD

Name: _____ Date of Birth: _____
Day Month Year

Person to be contacted in case of emergency: _____

Phone numbers: Day _____ Evening _____

Alternative contact: _____

Phone numbers: Day _____ Evening _____

Family doctor: _____ Phone number: _____

Hospital insurance number: _____

Medications: _____

**Relevant
Medical
History**

Allergies: _____

Previous injuries: _____

Does the participant carry and know how to
Administer his or her own medications? Yes: [] No: []

Other conditions (braces, contact lenses, etc.): _____

Note: Medical information is confidential. Keep this card with the team at all times. These cards should not be available to other than authorized individuals.