

Team Florida USA National Baseball Team

PLAYER MEDICAL TREATMENT FORM

Players Name _____ Birth Date _____

Mothers Name _____ Fathers Name _____

Address _____

City _____ State _____ Zip _____

HM Phone # _____ WK Phone # _____ Cell Phone # _____

If there is no answer at the numbers above please call the following:

Persons Name _____ Phone Number # _____

Family Doctor _____ Phone Number # _____

Medical Insurance: _____

Policy Number: _____ Date / Last Physical: _____

Do you have a history of diabetes or Epilepsy? Yes No

If yes, explain: _____

List Medicines you are allergic to: _____

I, _____, give permission to administer anesthetic and/or emergency treatment as required by the attending physician.

Parent or Guardian Signature: _____ Date: _____

Notary Signature: _____ Date: _____