LANGFORD MINOR FASTBALL ASSOCIATION
PLAYER INFORMATION FORM

Name: ____

Address: ____

Telephone: ______________ Postal Code: __________ Softball Ball BC # __________

Parents/Guardians: ______________________________________

Telephone — Home: ________________ Work: ________________________

IN THE EVENT OF EMERGENCY CONTACT: (Other than parent)

1st Name: __________________________ Telephone: ______________________

2nd Name: __________________________ Telephone: ______________________

Medical Plan # ______________________ Dental Plan # ____________________

Doctor's Name : _____________________ Telephone ______________________

PLEASE INDICATE IF YOUR CHILD HAS ANY OF THE FOLLOWING PROBLEMS BY CHECKING THE APPROPRIATE PLACE(S)

A) Vision _________ Glasses ___________ Contacts__________________

B) Hearing ________ Hearing Aid _______

C) Asthma ________ Requires Emergency Treatment ______________________

Specify Medicine ____

D) Allergies ____

Specify Medicine ____

E) Epilepsy _______ Type _____________ Medication Used ____________

F) Diabetes _______ Insulin ___________ Type of Insulin ______________

F) Other ____

I, ____ give the coaches

PLEASE PRINT NAME

permission to obtain emergency treatment for my son/daughter

____

CHILD'S NAME

Date ______________________________ ______________________________

Parent/Guardian

Date______________________________ ______________________________

Coach