



# MEDICAL EMERGENCY FORM

**250** ABSOLUTE BEGINNER'S GUIDE TO **COACHING YOUTH BASEBALL**

Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**IMPORTANT INFORMATION:**

1. Does your child take daily medication? Yes \_\_\_ No \_\_\_

If yes, please explain:

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2. Does your child have any drug, food, or insect allergies? Yes \_\_\_ No \_\_\_

If yes, please explain:

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3. Does your child suffer from \_\_\_\_\_ asthma, \_\_\_\_\_ diabetes, or \_\_\_\_\_ epilepsy?

Check all that apply.

4. Will your child be bringing any medication to practices or games? Yes \_\_\_ No \_\_\_

If yes, please name the medication and explain its purpose:

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5. Has your child had a tetanus shot? Yes \_\_\_ No \_\_\_

6. Is there anything else pertinent regarding your child's health or physical condition? Is yes, please explain:

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**List two people to contact in case of an emergency:**

Parent or guardian's name \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ Work phone \_\_\_\_\_

Second person's name \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ Work phone \_\_\_\_\_

**APPENDIX B** MEDICAL EMERGENCY FORM **251**

Relationship to child \_\_\_\_\_

Family doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health plan name \_\_\_\_\_

Health plan ID# \_\_\_\_\_

Parent or guardian's signature \_\_\_\_\_

Date \_\_\_\_\_

