

VOLLEYBALL FESTIVAL 2010
COACH'S MEDICAL FORM

COACH MEMBER _____

Last Name First Name Middle Initial

SOCIAL SECURITY # _____

MEDICAL HISTORY

Address _____ Birthdate _____ Age _____
City _____ State _____ Zip _____ Phone (____) _____

In an emergency, please contact:

_____ Emergency Phone (____) _____

Print Name/relationship

INSURANCE INFORMATION

Insurance Company _____ Policy # _____

Address _____ Group # _____

City _____ State _____ Zip _____ Phone (____) _____

MEDICAL HISTORY

I, staff member named above:

1. Have a history of epilepsy: Yes ___ No ___

2. Have a history of diabetes: Yes ___ No ___

3. Am subject to one of the specified: sleepwalking _____; ear infections _____; sinus _____;
indigestion _____; hives _____; hay fever _____; sore throat _____; bedwetting _____;
appendicitis _____; asthma _____; eye strain _____; heart trouble _____; poison oak _____;
allergic reaction to insect stings, bites _____; list allergies, if any: _____

4. Specific conditions, not covered above, which affect my participation or treatment:

5. Circle diseases you have had: chicken pox, diphtheria, German measles, mumps, scarlet fever, small pox, typhoid, whooping cough.

6. Give year of immunization: Tetanus _____ Polio _____

7. Am subject to penicillin or other drug reaction? _____ If so, what drug? _____

What reaction? _____

8. I am under special medical or dietary regime. These are listed below:

9. I will bring medicine with me? Yes ___ No ___ Name of drug: _____

10. Are there factors which would limit your full participation in activities? _____

If so, please explain: _____

11. Special needs _____