



Sarasota Senior Softball

PLAYER MEDICAL HISTORY

Please complete this form clearly. Information is intended for emergency reference only.

Player Information

Player Name: _____ Male Female Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Primary Medical Doctor

Doctor Name: _____ Doctor Phone: _____

Medications

Medication Name	Dose

Medical Issues

<input type="checkbox"/> Heart	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> AIDS
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Contact Lenses
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other

Allergies to Medications

Emergency Contacts

Name	Relationship	Phone