REPRESENTATIVE PLAYER MEDICAL FORM

NB: - If this form is being completed for a player over 18 years of age, he/she should provide details of his/her next-of-kin/emergency contact person.

Players Full Name: -		Age:
Name Wished to be Called By: -		
Contact Person: -		
Relationship to Player: -		
Contact Phone Number: -	Mobile:	Work:
Alternate Contact Number: -		
Email Address: -		
Family Doctor's: -	Dr's Name: Practice Name:	Phone Number:
Is your child taking any regular medication? If so, please state name and dosage: -		
Does your child suffer from any allergies? **If yes, please state treatment required:** Does your child suffer from Food allergies? **If yes, do they have special dietary requirements. Please list.**		
Does your child have any sport related injuries that we should know about? If yes, please give us as much information as possible including any assistance that may be required:		
It is understood that the management staff will try to the best of their ability to consult parents, prior to players receiving medical treatment, however in an emergency; I agree that my child will be able to receive any required medical treatment while representing Basketball Manawatu. I understand any medical costs not covered by ACC will be paid by me. I acknowledge that the above information is correct and that should there be any changes to any of the information, that it is my responsibility to advise the Team Manager asap. If there are special food requirements, I will supply the food my child is allowed to eat.		

Players Name _____ Signature _____
(If over 18 years of age)

Consenting Parent/Guardian Name _____ Date: ___/___/___

Consenting Parent/Guardian Signature _____