# Medical/Surgical Care/Emergency Treatment & Personal Medical Information

**Please Print Clearly**

**Name**: _____ **Team**: _____
Last name First Name

Home Address: _____
Street City State Zip Code
Home Telephone no: _____

College Address: _____
Street City State Zip Code
College Telephone no: _____

**Name of health insurance carrier**: _____

Identification Number: _____ Group Number: _____

**Emergency Contact information**:

Name: _____ _____
Last name First Name Relationship

Telephone #: _____ Cell Phone #: _____

**Are you currently taking any Prescriptions or Non-Prescription Medications?** YES NO **If yes, please list medications below:**

Anti-inflammatories _____ Muscle Relaxants_____

Pain Medication _____ Other_____

**Allergies**, if any, please identify: _____

**Do you now have or have you ever had ANY of the following?** Please check yes or no.

| | yes | no | | yes | no |
|---|---|---|---|---|---|
| Asthma, Bronchitis, or Emphysema | ____ | ____ | Severe or Frequent Headaches | ____ | ____ |
| Shortness of Breath/Chest Pain | ____ | ____ | Vision or Hearing Difficulties | ____ | ____ |
| Cancer or Chemotherapy/Radiation | ____ | ____ | Numbness or Tingling | ____ | ____ |
| Any Pins or Metal Implants | ____ | ____ | Hernia | ____ | ____ |
| Concussion (if yes, when?) | ____ | ____ | Arthritis/Swollen Joints | ____ | ____ |
| Joint Replacement | ____ | ____ | Blood Clot/Emboli | ____ | ____ |
| Back Injury/Surgery | ____ | ____ | Diabetes | ____ | ____ |
| Neck Injury/Surgery | ____ | ____ | Dizziness or Fainting | ____ | ____ |
| Elbow/Hand Injury/Surgery | ____ | ____ | Anemia | ____ | ____ |
| Any Pins or Metal Implants | ____ | ____ | Epilepsy/Seizures | ____ | ____ |
| Concussion (if yes, when?) | ____ | ____ | Heart Attack | ____ | ____ |
| Knee Injury/Surgery | ____ | ____ | Stroke/TIA | ____ | ____ |
| Leg/Ankle/Foot Injury/Surgery | ____ | ____ | High Blood Pressure | ____ | ____ |
| Any other surgeries? | ____ | ____ | Dizziness or Fainting | ____ | ____ |
| | | | Coronary Heart Disease or Angina | ____ | ____ |

**If you checked yes for any item, please explain**: _____

_____

_____

_____

**List any other information that would assist us in your care**: _____

_____

**Signature:** _____ **Date:** _____

**Witness:** _____ **Date:** _____

**This medical information form is to be kept in the possession of club head coach or another responsible person that insure its availability whenever the player involved is participating in a rugby match or practice session.**