

Player Emergency Information
Valley Junior Senior High School Baseball Program

Players Name: _____

Birth Date: _____

Parents Name: _____

Players Age: _____ Grade: _____

Home Address: _____

City: _____

State: Pennsylvania Zip Code: _____

Home Phone: () _____

Father Business Phone Number: () _____

Ext: _____

Father Cell Phone Number: () _____

Mother Business Phone Number: () _____

Ext: _____

Mother Cell Phone Number: () _____

Players Cell Phone Number: () _____

If no answer please phone in case of an emergency: Name: _____

Phone Number: _____

Family Physician: _____

Address: _____ City: _____

State: Pennsylvania Zip Code: _____

Phone Number: _____

Hospitalization Insurance: _____

Address: _____

Policy I D Number: _____

Group Number: _____

Phone Number: () _____

Date of last Tetanus Shot: _____

History of Diabetes or Epilepsy: _____

Allergies to any medications: _____

Other Allergies : _____

Parents /Guardian: permission to administer emergency treatment as required.

Yes

I give permission to the statement above.

No

I do not give permission to the statement above.

By signing this waiver and providing the information on this paper, you have agreed to the information provided by you and this statement. Player named above will be covered by his parents medical insurance listed on this paper. This insurance will cover you during practices, games and travel to and from games. By signing this form I wave my right as a player and I wave my right as a parent/guardian to hold the school, and its coaches responsible for my injuries and medical bills.

Signature of Parent/Guardian:_____

Signature of Player:_____

Date:_____