

MEMBERSHIP FORM

CONTACT INFO

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____ ZIP _____

Home PHONE _____ CELL _____ EMAIL _____

Dad's NAME _____ CELL _____ EMAIL _____

Mom's NAME _____ CELL _____ EMAIL _____

Player

Birth Date _____ GRADE _____ HIGH SCHOOL _____

If Senior: List post-graduation plans [College/where, Job/where, Other(Military, etc) , Undecided]

MEDICAL INFO

EMERGENCY Contact Name _____ Phone _____

Relationship _____ Cell _____

Health Insurance Carrier : _____ Phone _____

Policy No. : _____ Group No. : _____

Name of Insured Parent/Guardian _____

Primary Care Physician Name _____ Phone _____

Check if you have had any of the following injuries. If YES, please provide details (where, when, etc)

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Concussion	_____
<input type="checkbox"/>	<input type="checkbox"/>	Broken Nose	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Wrist/Hand	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hip Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other fractures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other significant injuries	_____

List approximate dates and details of surgeries not listed above: _____

List approximate dates and details of any other hospitalizations: _____

Check if you have had any of the following conditions.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, allergies, hay fever _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps/discharge _____
<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependencies _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental plate/broken tooth _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures _____
<input type="checkbox"/>	<input type="checkbox"/>	Heat illness/cramps _____
<input type="checkbox"/>	<input type="checkbox"/>	Hernia _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	Missing organ _____
<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Stomach Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Unusual bleeding _____
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss – sudden _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Please list all medications you are taking including prescriptions, over-the-counter meds, birth control pills and supplements: _____

Statement of Veracity and Consent to Treat:

I, (*player's name*), _____, hereby state that the above information is true and correct to the best of my knowledge. I also formally state that when not present I grant Rainier Plateau Junior Rugby Club's coach, Andy Ramsay, to obtain medical care from any licensed physician, hospital or clinic for the above mentioned participant, for any injury that could arise from participation in club-related events.

Athlete's Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____
Printed Name _____ *Relationship:* _____