

West Coast Fantasy Baseball Association

Health and Emergency Contact Information

The participant must complete this health and emergency contact form.

Emergency Contact

Participant's Last Name	First Name	Date
Primary Emergency Contact	Day Telephone	Evening Telephone
Alternate Emergency Contact (if primary contact cannot be reached)	Day Telephone	Evening Telephone

Health History

(Check all that apply)

<input type="checkbox"/> Bleeding or Clotting Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Heart Defect or Disease	<input type="checkbox"/> Prophylaxis
<input type="checkbox"/> Other (Describe) _____		

Allergies

(Check all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Insect Bites/Stings (Specify) _____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Food (Specify) _____
<input type="checkbox"/> Other (Describe) _____	

Medications

Specify all medications currently being taken and describe any reactions _____

Health/Accident Insurance Information

Name of Policy Holder	Insurance Company	Policy/Group Number
Personal Physician	Physician's Telephone	