

# West Coast Fantasy Baseball Association

## Health and Emergency Contact Information

The participant must complete this health and emergency contact form.

### Basic Contact Info

Participant's Last Name	First Name	Date
Participant's Address	City,	State Zip
Participant's Primary Phone	Secondary Phone	Email

### Emergency Contact Info

Primary Emergency Contact Name	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	