West Coast Fantasy Baseball Association

Health and Emergency Contact Information

The participant must complete this health and emergency contact form.
(Fields in red must be completed)

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)

- ☐ Bleeding or Clotting Disorder
- ☐ Diabetes
- ☐ Seizures
- ☐ Frequent Ear Infections
- ☐ Heart Defect or Disease
- ☐ Prophylaxis
- ☐ Other (Describe) _____

Allergies

(Check all that apply)

- ☐ Asthma
- ☐ Insect Bites/Stings (Specify) _____
- ☐ Penicillin
- ☐ Food (Specify) _____
- ☐ 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