2020/2021

EMERGENCY MEDICAL INFORMATION

PLAYER		DATE OF BIRTH	
DAD'S NAME		Emergency Phone Number	
DAD'S ADDRESS			
EMPLOYER			
MOM'S NAME		Emergency Phone Number	
MOM'S ADDRESS If different			
EMPLOYER			

FAMILY HEALTH INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF INSURANCE CARD OR NECESSARY INFORMATION / FORMS)

PRIMARY INSURED			
PLAYER'S PHYSICIAN		PHONE #	

ALLERGIES / PHYSICAL CONCERNS THAT NEED TO BE KNOWN BY COACHING STAFF

I / We hereby grant consent to any and all health care providers designated by the Ohio Ultimates Fastpitch Softball to obtain for my / our child _____ any necessary medical care as a result of any injury / illness in my / our absence.

Mother's Signature_____ Date _____

Father's Signature _____ Date _____

The Ohio Ultimates Fastpitch provide an additional insurance policy on all players as a secondary insurance plan. Coverage is $250,000 medical and $2 million liability.