Mayville Sting
MEDICAL INFORMATION FORM

Family Physician: Dr. _____ Phone (_____) _____

Address: _____
Street City State Zip Code

Medical Office or Clinic: _____Phone (_____) _____

Address: _____
Street City State Zip Code

Family Dentist: Dr. _____ Phone (_____) _____

Address: _____
Street City State Zip Code

Allergies: _____

Medications: _____ _____
Name, Dosage, Frequency Name, Dosage, Frequency

Medications must be stored in their original containers

I also authorize for my daughter to take the following type of over-the-counter medications, if necessary:
- ❑ Acetaminophen (Tylenol), _____ tablets, capsules or caplets
- ❑ Ibuprofen (Advil, Nuprin), _____ tablets, capsules or caplets

Date of Last Tetanus Toxoid Booster: _____

Medical Insurance Company: _____

Address: _____
Street City State Zip Code

Policy Holder Name: _____ Policy Number: _____

Group Number: _____ Subscriber Number: _____

IN CASE OF EMERGENCY, I authorize a qualified and licensed physician to treat my child.

_____ _____ _____ _____
Player name Parent name (printed) Parent Signature Date Signed

PLEASE ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD. This document will be secured and referred to in emergency situations only.