# 2023 Medical Information Form

*This form only has to be completed once per season.*

Name: ______________________________ Date of Birth: ______________________

Address: ______________________________ Phone: ______________________

City: ______________________________ State: __________ Zip Code: ______________

Medical Insurance Company: ____________________________________________

ID Number: ______________________________ Phone: ______________________

Alternate Medical Insurance: ____________________________________________

ID Number: ______________________________ Phone: ______________________

Emergency Contacts: 1) ______________________________ Phone: ______________________

2) ______________________________ Phone: ______________________

Date of last physical exam: ______________________ Blood Type: ______________________

Significant medical history (check those that apply):

[ ] Contact Lenses
[ ] Diabetes
[ ] Heart Disease
[ ] Pacemaker
[ ] Arrhythmia
[ ] Head Injuries
[ ] High Blood Pressure
[ ] Seizure Disorder
[ ] Asthma/Respiratory Problems
[ ] Blood Problems (anemia, clotting difficulties)
[ ] Musculoskeletal Problems
[ ] Malignancy
[ ] Other: ____________________________________________

____________________________________________

Past Surgical History: ____________________________________________

____________________________________________

____________________________________________

Prescription Medications: ____________________________________________

____________________________________________

____________________________________________

____________________________________________

Allergies to Medications: ____________________________________________

____________________________________________

Emergency Authorization: *In case of emergency wherein I am incapable of giving consent due to illness or injury, I hereby authorize ECTA, LLC to share this information with any qualified person and for those individuals to administer first aid and/or other necessary treatment. Further, I authorize any licensed surgeon to perform surgery, if two (2) physicians qualified to make such judgment agree upon the need for surgery.*

Signature: ______________________________________________ Date: ____________________