<u>Permission and Health Form</u> - (16 years or over) **Team name:** _____

Name of player (including middle name): _____
Date of birth: _____
Team name: _____

I give permission to be taken to a doctor in the event of injury or illness
Signed: _____**Date:** _____

Doctor
Name: _____
Address: _____
Phone: _____

Emergency Contact (during tournament)
Name: _____
Address: _____
Phone: _____

Alternative Emergency Contact
Name: _____
Address: _____
Phone: _____

Do you have any of the following? (Please circle yes or no)
Asthma Yes/No
Diabetes Yes/No
Sleepwalking Yes/No
Epilepsy Yes/No
Allergies Yes/No
Other that we should know about: _____

Will you have any medication with you? Yes/No
If yes, please detail type and dosage: _____
_____

Do you have any dietary needs? Yes/No
If yes, please detail: _____
_____
Date of last tetanus injection: _____
Any other medical problems? _____
I give permission for my photo to be used on the WHA website and/or social media?
Yes/No (if you wish to have further clarification please contact WHA Administrator)