Adventure at Burritt's
TRAINING & SPORTS COMPLEX

BOGDAN SKLZ

SALT CITY SKLZ ACADEMY

MEDICAL INFORMATION & EMERGENCY CONTACT FORM

2026/27 PROGRAM YEAR

This form must be completed by a parent or legal guardian before participation in any training, academy program, camp, clinic, tournament, event, or related activity.

PARTICIPANT INFORMATION

Athlete Full Name: _____ Date of Birth: _____ Gender: _____

Program / Team: _____

Parent / Guardian Name: _____ Relationship to Athlete: _____

PRIMARY EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell Phone: _____

Alternate Phone: _____

Email: _____

SECONDARY EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell Phone: _____

Alternate Phone: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____

Phone: _____

Clinic / Hospital: _____

HEALTH INSURANCE

Insurance Company: _____

Policy Number: _____

Group Number: _____

Subscriber Name: _____

MEDICAL HISTORY

Please check all that apply.

- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Bleeding Disorder
- ☐ Concussion History
- ☐ Migraines
- ☐ Severe Allergies
- ☐ EpiPen Required
- ☐ ADHD
- ☐ Autism Spectrum
- ☐ Anxiety
- ☐ Other: _____

ALLERGIES

Please list all allergies (food, medication, insect stings, environmental, etc.)

_____

_____

_____

_____

MEDICATIONS

List all medications currently taken by the athlete.

Medication	Dosage	Reason

MEDICAL CONDITIONS / RESTRICTIONS

Please describe any medical conditions, previous surgeries, injuries, physical limitations, or restrictions coaches should know about.

_____

_____

_____

SPECIAL INSTRUCTIONS FOR COACHES

Anything else staff should know?

_____

_____

_____

EMERGENCY MEDICAL AUTHORIZATION

In the event of illness or injury, I authorize Bogdan SKLZ, Salt City SKLZ Academy, Adventure at Burritt Sports, their coaches, staff, employees, volunteers, contractors, and authorized representatives to obtain emergency medical treatment for my child if I cannot be reached immediately.

This authorization includes transportation by Emergency Medical Services (EMS), urgent care evaluation, hospital treatment, diagnostic testing, emergency surgery if deemed medically necessary by licensed medical professionals, and related emergency care.

I understand every reasonable effort will be made to contact me before treatment whenever circumstances permit.

I accept full financial responsibility for all medical expenses incurred.

☐ YES ☐ NO

MEDICATION ADMINISTRATION

May staff administer the following if necessary and permitted by law?

Bandages / First Aid	☐ Yes	☐ No
Ice Packs	☐ Yes	☐ No
EpiPen (provided by parent)	☐ Yes	☐ No
Inhaler (provided by parent)	☐ Yes	☐ No
Other physician-authorized emergency medication	☐ Yes	☐ No

PARENT / GUARDIAN CERTIFICATION

I certify that all medical information provided is accurate and complete to the best of my knowledge.

I understand that I am responsible for notifying Bogdan SKLZ immediately of any changes in my child's medical condition, medications, allergies, emergency contacts, or health status.

I acknowledge that this Medical Information & Emergency Contact Form supplements the Master Athlete Development, Liability, Payment & Protection Agreement and does not replace it.

Athlete Name: _____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Participant ID: _____

Medical Information Reviewed By: _____

Date Received: _____

Emergency Information Verified: ☐ Yes ☐ No

Notes: _____

_____

_____

_____