KNIGHTS BASKETBALL
KAMIAK'S YOUTH FEEDER PROGRAM

Mukilteo Knights Basketball Player Information Form

Player's Name_____ Date of Birth_____

Father's Name_____Mother's Name_____

Address_____

City_____, WA Zip_____

Cell Phone_____Text (Y-N) Cell Phone_____Text (Y-N)

Medical Release – Parent/Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician).

Family Physician_____ Phone_____

Address_____

Hospital Preference_____

In case of emergency, contact:

Name Phone Relationship to Player

1)_____

2)_____

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis Medication Dosage Frequency of Dosage

_____

_____

_____

_____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Authorized Parent/Guardian Signature:_____Date:_____