MID-AMERICA GAMES FOR THE DISABLED, INC.

P.O. Box 1342, Mission, Kansas 66202-1342
www.midamericagames.com

STAFF INFORMATION FORM

Name: _____ Phone: (day) _____ (night) _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ Date of Birth: _____

Team Affiliation: _____ Shirt Size: _____

Your position: (check all those that apply)

___ Head Coach ___ Assistant Coach ___ Personal Care Attendant ___ Other _____

HEALTH INFORMATION

PERSON TO CONTACT IN AN EMERGENCY: _____

Relationship: _____ Phone: (_____)_____

Physician's Name: _____ Phone: (_____)_____

Physician's Address: _____

Insurance Company: _____ Policy #: _____

Do you or have you had any of the following medical/health problems? (If YES, please specify)

Allergies	_____No	_____Yes	_____
Drug Allergies	_____No	_____Yes	_____
High Blood Pressure	_____No	_____Yes	_____
Asthma	_____No	_____Yes	_____
Heart Disease	_____No	_____Yes	_____
Diabetes	_____No	_____Yes	_____
Seizures	_____No	_____Yes	_____
Other: _____	_____No	_____Yes	_____

PLEASE ENCLOSE ANY PERTINENT HEALTH/MEDICAL INFORMATION FROM YOUR PHYSICIAN

Are you currently taking any medications? _____No _____Yes
If yes, please list: _____

Date of last tetanus shot: _____

We suggest that you discuss your participation in the Mid-America Games for the Disabled, Inc. with your physician and get his/her approval for participation.

Permission is given to Mid-America Games for the Disabled, Inc., a representative of the local team, or competition organizing committee to seek medical care in case of an emergency for the above named person.

_____ _____
Signature Date

_____ _____
Signature of Parent/Guardian if person is under 18 Date