

2026 Hudson Girls Softball

Medical Consent & Emergency Information

Player Name _____ DOB: _____ Age: _____

Main Emergency Contact: _____ Phone: _____

Emergency Contact 2: _____ Phone: _____

Medical History

Allergies to:

Medications: NO YES _____ Insects: NO YES _____ Foods: NO YES _____

Circle either YES or NO regarding the following conditions. If "YES" please explain in line or on the reverse side.

Dizziness/ Fainting:	NO	YES	_____	Recurrent Headaches:	NO	YES	_____
Asthma:	NO	YES	_____	Head Injury/Concussion:	NO	YES	_____
Diabetes:	NO	YES	_____	Heart Ailments/Condition:	NO	YES	_____
Epilepsy/Seizures:	NO	YES	_____				

Please describe any:

SURGERIES OR HOSPITALIZATIONS? NO YES

ANY MEDICATIONS TAKEN REGULARLY THAT AN AMBULANCE COMPANY OR HOSPITAL NEEDS TO KNOW ABOUT IN AN EMERGENCY? NO YES

PLEASE LIST ALL MEDICATIONS AND DOSAGES:

Emergency Authorization and Consent:

As the parent/guardian of _____, I hereby give permission to the Staff/Coaches of Hudson Girls Softball to administer first aid to my child and/or in the event of an emergency, secure proper treatment in the form of contacting emergency medical services. To the best of my knowledge, this medical history form is correct and I will update my child's medical conditions as necessary until this consent is no longer valid.

Signature of Participant/Guardian: _____ Date: _____

Print Name: _____ Relationship: _____

*** This consent is valid for one (1) full season. Please remember that it is critical to update the coach(es) should any of this information change during the season. Most importantly pertaining to concussions/allergies and/or medications. ***