

Wheelchair Basketball Player Health Disclosure Form

Personal Details

Full Name

Date of Birth

Team/Club

Email Address

Phone Number

Medical Information

Type of Disability/Condition

Relevant Medical History

Allergies (medication, food, environmental)

Current Medications

Emergency Contact Name

Emergency Contact Phone

Consent & Declaration

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I consent to medical treatment in case of emergency.

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I declare the information provided is accurate and complete.

Signature

Date