# Native Stars Basketball - Coaches
# Medical and Dental Information Form

## PERSONAL INFORMATION

Name: ______________________________ Coaches Title: ________________

Address: ________________________________________________________

City: __________________ Zip code: _________ Emergency Phone: ____________

Home Phone: _____________Cell: __________________ Work: _______________

Email Address: ____________________________________________________

## AUTHORIZATION FOR MEDICAL / DENTAL TREATMENT

I take all responsibility concerning my physical condition upon entering the Native Stars Basketball (NSB) program. In case of emergency, if any medical or dental treatment becomes necessary while participating in the NSB program, I hereby give NSB program personnel my permission to use their judgment in obtaining medical or dental treatment. I give the emergency medical or dental personnel my permission to render any required medical treatment. I understand costs incurred will be my responsibility. Furthermore, I will not hold the Native Stars Basketball program or its training facility liable for any damages or injuries.

Coaches Signature: ______________________________ Date: ______________

## INSURANCE COMPANY INFORMATION

Medical Insurance Company: ___________________________________________
Address: _________________________________________________________
Phone: __________________________________________________________
Policy Number: ____________________________________________________
Dental Insurance Company: ___________________________________________

## MEDICAL INFORMATION (medication, allergies, surgeries, ect.)

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

## IN CASE OF EMERGENCY

CONTACT: ________________________________________________________
HOME PHONE: ____________________ CELL PHONE: ___________________
ADDRESS: ________________________________________________________