MEDICAL FORM
KIN-BALL® SPORT WORLD CLUB CHAMPIONSHIP 2015

INFORMATION

NAME		FIRST NAME	
TEAM		DATE OF BIRTH	

IN CASE OF EMERGENCY

PERSON TO CONTACT			
TELEPHONE		MOBILE	
ADDRESS			

MEDICAL SITUATION

ARE YOU SUFFERING FROM:			
	YES OR NO	IF YES, WHICH ONE?	DO YOU HAVE MEDICATIONS?
ALIMENTARY ALLERGIES			
MEDICATION ALLERGIES			
HEALTH PROBLEMS			

MEDICAL INSURANCE

NUMBER		COMPANY	

AUTHORIZATION

I authorize the Spanish KIN-BALL® Sport Federation to give me all necessary help and/or to organize ambulance-transport in case of emergency.

DATE	
SINGNATURE	

(The signature from a parent is necessary for young ones under 18 years old accompanying delegations)