

**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