



Lincolnshire Bombers American Football Team – Health Care Plan

Name:		Date of birth:	
Address		Medical condition:	
Date:		Review date	
Emergency Contact Information			
Name			
Address			
Work			
Home			
Mobile			
Hospital Contact:		GP Details	
Phone Number:			
Describe medical needs and give details of any possible symptoms			
Daily care requirements (if applicable)			
Describe what constitutes an emergency for the above named person, and the action taken if this occurs			
Who is responsible in an emergency (state if different for off-site activities)			
Form copied to :			

Parent/Carers signature Print.....

Signature of Welfare Officer Print.....

Club Representatives sign to say you have read and understood:-

Mark Harrison

Alan Chambers