TEAM CONTACT DETAILS

TEAM:_____ AGE: U____ M / F

COACHES NAME :_____
DAYTIME PHONE:_____HOME PHONE:_____
Email address:_____

PLAYERS NAME	CONTACT NAME	TELEPHONE #1.	TELEPHONE #2	ILLNESS, ALLERGIES, MEDICATION

This form must be filled out by each team prior before the first session can begin and be kept with the trainer at all times when you are training and or at games.