

Medical Information and Authorization to Treat

Homestead Lacrosse Club

Name _____ Age _____ School _____

Address _____

Parent/Guardian Name _____

Home Phone _____ Cell Phone _____

Parent/Guardian Name _____

Home Phone _____ Cell Phone _____

Drug Allergies _____ Last Tetanus _____

Current Medications _____

Health Concerns (asthma, prior injury, etc.) _____

Physician _____ Phone Number _____

Medical Insurance Carrier _____ Policy Number _____

Alternative Emergency Contact _____ Phone _____

Authorization for Medical Treatment

I (we) realize that our minor-aged child who is participating in athletic events in association with the Homestead Lacrosse Club may become injured to a degree which would require medical attention. I (we) authorize the Club or its agent to make decisions which shall be deemed reasonable and prudent in acquiring proper medical attention. In addition, I (we) authorize any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to my (our) child under the general or special license to practice medicine in the state which the event is being held. In such cases, the Club or its agent shall make all attempts to contact myself (ourselves), the listed doctor, or alternative contact person for verbal authorization of treatment.

Dated this _____ day of _____, 20____.

Signature of Parent or Legal Guardian