

Wenatchee Valley Lacrosse Club

Release Form for Medical and/or Hospital Treatment

I, _____ (parent) hereby grant permission for the properly designated Wenatchee Valley Lacrosse personnel to administer emergency care to _____ (player) on site and/or give permission for medical treatment as required at the closest hospital or other such medical facility. I assume responsibility for any medical bills which may be incurred. I further release Wenatchee Valley Lacrosse Club, US Lacrosse and/or their representatives from responsibility for any problems that might arise as a result of medical care and or treatment. This includes any hospital or other facility utilized in the treatment of the player.

parent/guardian signature

date

GENERAL INFORMATION

Player division:

Parent/guardian:

Parent/guardian:

Home phone:

Home phone:

Work phone:

Work phone:

Mobile phone:

Mobile phone:

OTHER EMERGENCY CONTACTS (list two)

Name/Relation:

Name/Relation:

Home phone:

Home phone:

Work phone:

Work phone:

Mobile phone:

Mobile phone:

MEDICAL INSURANCE COVERAGE

Insurance company:

Group Number:

Policy Number:

Primary Physician:

Phone:

MEDICAL HISTORY (complete as applicable)

Allergies Please list:

Asthma

Bee sting sensitivity

EPI Pen?

Pen location:

Epilepsy/Seizures

Diabetes

Relevant medical/surgical history

Please list:

Daily medication

Please list/frequency:

Other information: