Upstate Lacrosse Association- U.L.A. INC.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAME OF MINOR____ BIRTH DATE_____________

IDENTIFY ALLERGIES OR SPECIAL CONDITIONS:
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____

I/WE, BEING THE PARENTS(S) OR LEGAL GUARDIANS(S) OF THE ABOVE NAMED MINOR, DO HEREBY APPOINT (THE COACHES NAMES GO HERE):

NAME ADDRESS PHONE

1.____
____

2.____
____

TO ACT IN MY/OUR BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE NAMED MINOR(S) DURING THE PERIOD OF MY/OUR ABSENCE FROM:

For the 2020 ULA Season

THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTIST OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTIST, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED.

1.

____

PARENT GUARDIAN SIGNATURE ADDRESS PHONE

____

WITNESS SIGNATURE ADDRESS PHONE

HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S):

1.

____

INSURANCE COMPANY I.D. OR CONTRACT NUMBER

HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S):

2.

____

INSURANCE COMPANY I.D. OR CONTRACT NUMBER

FAMILY PHYSICIANS:

1. ______________________________

______________ NAME AND NUMBER

FAMILY PHYSICIANS:

2. ______________________________

______________ NAME AND NUMBER