

MIDDLETOWN YOUTH LACROSSE MEDICAL RELEASE FORM

The purpose of this form is two-fold:

1. To obtain parent or guardian for a coach to seek medical treatment for a player in the event that such treatment is required and when a parent or guardian cannot be contacted.
2. To collect information that will help to ensure medical personnel has necessary details of any medical conditions, which may interfere with or alter treatment.

Note: This information is to be carried by the team manager or coach to each team function together with the team roster and other team-related information. This information will be discarded at the end of the season.

Player Name: _____	DOB (mo-dd-yyyy): _____
Family Physician: _____	Physician Phone: _____
Physician Address: _____	Hospital Preference: _____
Dentist: _____	Dentist Phone: _____

In case of emergency contact:

Name _____	Cell Phone: _____	Home Phone: _____	Relationship to player _____
Name _____	Cell Phone: _____	Home Phone: _____	Relationship to player _____

If parents/guardian are not available other emergency contact:

Name _____	Cell Phone: _____	Home Phone: _____	Relationship to player _____
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Date of last tetanus booster: _____	_____
Known allergies incl. medicine: _____	_____
Known medical problems: _____	_____
Other: _____	_____

Person responsible for payment of medical bills and fees:

Name _____	Relationship to Player _____	Home Phone _____	Cell Phone _____
Address _____	Insurance Carrier _____	Policy Number _____	

I _____ (Parent/Guardian's Name) hereby authorize my child _____ (Child's Name) to be treated by medical personnel (e.g. EMT, First Responder, E.R. Physician) in the event of an accident, injury, or other medical emergency during team functions when I cannot be contacted.

Signature of Parent/Guardian _____ Date: _____