

Upper St. Clair Girls Youth Lacrosse Player's Medical Information

Player's Name: _____ Age: _____ Birth Date: _____

Street Address: _____

Home Telephone: _____

Family Email Address: _____

Parent Name: _____ Cell Phone: _____

Other Email Address: _____

Parent Name: _____ Cell Phone: _____

Other Email Address: _____

In an emergency when parent/guardian cannot be reached, please contact the following:

Name: _____ Phone 1: _____ Phone 2: _____

Name: _____ Phone 1: _____ Phone 2: _____

Please list allergies the player has:

Please list other medical conditions:

Name of Physician: _____ Phone: _____

Medical/Hospital Insurance Company: _____

Medical Treatment Authorization and Liability Waiver

I hereby give my consent to have an athletic trainer, coach, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation for the participant to a medical treatment facility should an individual listed above consider it to be warranted. I recognize the possibility of physical injury associated with girls lacrosse, and hereby release, discharge, and otherwise indemnify the club, Upper St. Clair Girls Youth Lacrosse, their sponsors, WPSLA (Western Pennsylvania Scholastic Lacrosse Association), US Lacrosse, and its affiliated organizations, and associated personnel of these organizations, against any claim by or on behalf of the girls lacrosse player named above as a result of that player's participation in the Upper St. Clair Girls Youth Lacrosse program and/or being transported to or from the same, which transportation I hereby authorize.

Signature: _____ Date: _____

