Coral Springs Chiefs Lacrosse - Player Medical Form

____

Player   Last Name   First Name

Male ___ Female ___   Birthdate   /   /   (Month /Day /Year)

____

House # Street Name

_____________________   _______________   _____________________

City   State   ZIP Code

Telephone Number: (   ) ________________________

School Attending: ____

List Any Medical Problem or Prohibition Player Has:______________________________________

____

Parent/Guardian (please print): ____

Person to Notify in Emergency: ____________________________________ Phone: ____________________

Alternate Emergency Contact: ____________________________________ Alt. Phone: ________________

Doctor to Notify in Emergency: ____________________________________ Phone: ____________________

Hospital Preference, If Any ______________________________ City: ____________________________

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CONSENT TO TRANSPORT:

THE UNDERSIGNED, PARENT/GUARDIAN OF MINOR ______________________DO HEREBY AUTHORIZE THE OFFICER, LEADER, OR COACH, AGENTS OF CORAL SPRINGS YOUTH LACROSSE TO TRANSPORT AS REQUIRED THE ABOVE MINOR TO AND FROM CORAL SPRINGS YOUTH LACROSSE SPONSORED ACTIVITIES INCLUDING BUT NOT LIMITED TO ATHLETIC EVENTS.

Signature of Parent/Guardian ____

CONSENT FOR MEDICAL TREATMENT (MINOR) :

I HEREBY GIVE MY CONSENT FOR ALL MEDICAL CARE PRESCRIBED BY A DULY LICENSED DOCTOR OF MEDICINE FOR ___________________________ AS HIS/HER PARENT OR LEGAL GUARDIAN. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL-BEING OF MY DEPENDENT.

Date: ______________ Signed: ____

Address: ____Phone: ____________

City: ____Zip: ______________