



PLAYER INFORMATION & MEDICAL RELEASE FORM

Player's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
E-mail address: _____ Expected HS Grad Yr: _____

EMERGENCY INFORMATION

Father's Name _____ Home Phone:(____) _____ Cell:(____) _____
Email Address: _____
Mother's Name _____ Home Phone:(____) _____ Cell:(____) _____
Email Address: _____

In an emergency when parents cannot be reached, please contact:

Name _____ Home Phone:(____) _____ Cell:(____) _____
Name _____ Home Phone:(____) _____ Cell:(____) _____

Allergies:

Other medical conditions:

Injuries in the past 12 months:

Player's Physician _____ **Phone:**(____) _____

Medical and/or Hospital Insurance Company _____

Address: _____ Phone: (____) _____

Policy Holder _____

Policy # _____ Group # _____

PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD & ATTACH TO THIS FORM

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with lacrosse and in consideration for the US Lacrosse/HLA and its affiliates accepting the registrant for its lacrosse programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the US Lacrosse/HLA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize. My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs.

I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of such assistance and/or treatment.

(Parents Printed name)

(Parents Signature)