STANWOOD LACROSSE
MEDICAL TREATMENT AUTHORIZATION

1. Player's name: _____ Team: _____

2. Player's date of birth: _____ Age: _____

As the parent or guardian of the above named player, I request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment.

I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine, or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and xray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

_____ _____

3. Parent/guardian's printed name and signature Date

4. Parent/guardian phone number(s): _____

5. List medical conditions/allergies (include previous concussions/head injuries):

6. Doctor's name: _____ Doctor's phone: _____

7. Doctor's location: _____

8. Emergency contacts and phone numbers (also list 2nd parent/guardian):