

# 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

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: \_\_\_\_\_