ALLIED SPORTS of VIRGINIA

MEDICAL RELEASE FORM

PLEASE PRINT: I hereby give my permission for my child (full name) _____to participate in the FALL BRAWL TOURNAMENT hosted by Allied Lacrosse and play all games for his/her team. I further give my permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. This release is in effect for the FALL BRAWL TOURNAMENT being held on _____, 20_____. I also hereby assume the responsibility for the payment of any such treatment.

PARENT'S NAME: _____

PARENT'S ADDRESS: _____

_____

HOME PHONE: _____ MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

MY INSURANCE COMPANY IS: _____

MY POLICY NUMBER IS: _____

In case I cannot be reached, either of the following is my designated representative:

COACH: _____ PHONE: _____

ASST COACH: _____ PHONE: _____

OTHER: _____ PHONE: _____

OUR FAMILY PHYSICIAN: _____

ADDRESS: _____ PHONE: _____

KNOWN ALLERGIES OR OTHER MEDICAL CONCERNS: _____

DATE OF LAST TETANUS SHOT: _____

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE: _____

Please notify the following person if you are unable to locate me:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____