

# MADISON AREA LACROSSE ASSOCIATION PLAYER REGISTRATION FORM

Please fill out and return to your team representative.

Club/School Name \_\_\_\_\_

Player Name \_\_\_\_\_

Address \_\_\_\_\_ US Lacrosse # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ e-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ e-mail \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ e-mail \_\_\_\_\_

**WAIVER & RELEASE:** I am fully aware of and appreciate the risks, including the risks of catastrophic injury, paralysis and even death, as well as other damages and losses, associated with participation in a lacrosse event. I agree on behalf of myself, my heirs and personal representatives, that US Lacrosse, Madison Area Lacrosse Association, the host organization and the sponsor or sponsors with respect to a Covered Event, together with coaches, officials, volunteers, employees, agents, officers and directors of the host organization and any such sponsors shall not be held liable for any injury, loss of life or other loss or damage as a result of my participation. This Waiver & Release shall also be for the benefit of and run in favor of any youth organization that requires participants to become members of US Lacrosse as a condition to their participation in such organization's youth lacrosse events, which shall constitute Covered Events for purposes of this Waiver & Release, and any such youth lacrosse league shall constitute the host organization for such Covered Events.

**FOR ANY PARTICIPANT WHO IS NOT YET 18 YEARS OLD:** As legal parent or guardian of this participant, I hereby verify by my signature below that I fully understand and accept each of the above conditions for permitting my child to participate in any Lacrosse event and accept each of the above conditions of the waiver and release.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Parent/Guardian \_\_\_\_\_

\_\_\_\_\_ Check here if you do **not** give permission for your player to be photographed or have name released to appropriate Lacrosse organizations.

# MALA – Consent to Treat Form

This is to certify that I, \_\_\_\_\_, as parent or guardian of \_\_\_\_\_, give my consent to Madison Area Lacrosse Association, our team's coaches and representatives to obtain medical care from any licensed physician, medical care provider, hospital, or clinic for the above mentioned athlete, for any injury that could arise from participation in the game of lacrosse.

Name of Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ Policy \_\_\_\_\_  
Number \_\_\_\_\_ Insured # \_\_\_\_\_

## In case of Emergency, please notify:

Player's Name \_\_\_\_\_  
*Parent/Guardian #1* \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
*Parent/Guardian #2* \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Emergency contact (if parents/guardian unavailable) \_\_\_\_\_  
\_\_\_\_\_

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Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Clinic Address \_\_\_\_\_  
Hospital Preference \_\_\_\_\_

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If emergency treatment is required and the parent/guardian cannot be reached immediately, may team coaches and representatives use their own judgement in calling the physician indicated on the Medical History Form or if not available, an alternate physician or medical provider?      **YES**      **NO**  
(if no, please indicate alternate plan to follow)  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Team Reps: Please give original Consent Form to the coach and keep a copy for your records.**

# MALA Medical History Form

**Player Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Birth date** \_\_\_\_\_

If the answer to any of the following question is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

**Have you had (or do you presently have) any of the following, please circle:**

Head Injury (concussion, skull fracture)	<b>Yes</b>	<b>No</b>
Fainting spells	<b>Yes</b>	<b>No</b>
Convulsions/epilepsy	<b>Yes</b>	<b>No</b>
Neck or back injury	<b>Yes</b>	<b>No</b>
Asthma	<b>Yes</b>	<b>No</b>
High blood pressure	<b>Yes</b>	<b>No</b>
Kidney problems	<b>Yes</b>	<b>No</b>
Hernia	<b>Yes</b>	<b>No</b>
Diabetes	<b>Yes</b>	<b>No</b>
Heart murmur	<b>Yes</b>	<b>No</b>
Allergies	<b>Yes</b>	<b>No</b>
Specify: _____		
Injuries to:		
Shoulder	<b>Yes</b>	<b>No</b>
Knee	<b>Yes</b>	<b>No</b>
Ankle	<b>Yes</b>	<b>No</b>
Fingers	<b>Yes</b>	<b>No</b>
Arm	<b>Yes</b>	<b>No</b>
Other: _____	<b>Yes</b>	<b>No</b>
Impaired vision	<b>Yes</b>	<b>No</b>
Impaired hearing	<b>Yes</b>	<b>No</b>
Other: _____		

Have you had a recent tetanus booster? \_\_\_\_\_ If so, when? \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ What? Why? \_\_\_\_\_

Please explain any restrictions the doctor has placed on your activity? \_\_\_\_\_

Any other information that would be medically helpful? \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Team Reps: Please give original Medical History Form to the coach and keep a copy for your records.**