Southington Lacrosse Association

P.O. Box 345 Southington, CT. 06489

Medical Treatment Release & Doctors Form

I/We, the parents or legal guardian(s) of:

Name: _____ Sex: _____ Age: _____

Address: _____ Zip: _____ Birth Date: _____

Phone #: _____ Emergency # _____ Relationship: _____

an unemancipated minor, do hereby delegate to the coaches, organizers, or chaperones of the *Southington Lacrosse Association*, the authority to seek, obtain, and approve and medical care and treatment for the above named minor, which in their judgment is necessary fore health and well being of, said minor during his/her involvement with the Southington Lacrosse Association team. Further, I/We agree to hold its organizers, coaches, chaperones, or any other parties or agents harmless for any liability arising out of the good faith actions taken in seeking and obtaining said medical treatment of the above named minor.

It is understood that this authorization is given in advance of any specific diagnosis; treatment, or medical care being required and will serve as specific consent to all emergency treatment or hospital care.

I/We understand that we are responsible for any costs incurred that are not covered by our insurance, or the team's secondary insurance after deductibles are met. I/We have read the above and agree to these terms.

Parent(s) Signature _____ Parent(s) Name Print _____

Physical Examination
(To be completed by a licensed Physician, for above mentioned):

Overall health: ___Satisfactory __ Not Satisfactory ___Not Examined

Height· _____ , Weight _____ , Blood pressure, Nose, Eyes Glasses/Contacts, Hearing Right & Left, Throat, Heart, Lungs, Genitalia.

Restrictions & Limitations (Including Diet) _____

Allergies _____ Chronic/Recurring illness _____

Physician information:

Examing Physician (Signature): _____ Date: _____

Print Physician's Name: _____ .'Telephone: _____

Date Licensed: _____ License Number. _____ Address: _____