



# Wallingford Lacrosse Club

## Release Form for Medical and/or Hospital Treatment

Participant's US Lacrosse Number: .....

Participant's Date of Birth: .....

I .....hereby grant permission for the properly designated Wallingford Lacrosse Club Personnel to administer emergency care on site or at Mid-State Medical Center, Yale-New Haven Hospital, or other such facility rendered to my child..... while he is under their supervision/care.

Parent's Name: .....

Address: .....

Telephone: (H)..... (W) ..... Fax.....

Email: .....

### MEDICAL INSURANCE COVER:

Name of Company and Policy Number: .....

### OTHER (Relative or Friend) EMERGENCY CONTACT (list two)

Name	Relation	Phone Number	Email
.....	.....	.....	.....

Name	Relation	Phone Number	Email
.....	.....	.....	.....

### MEDICAL HISTORY: (Fill in the blanks where applicable)

Known Allergies .....

Epilepsy/Seizures ..... Diabetes.....

Asthma ..... Bee Sting sensitivity.....

Relevant Medical/Surgical History.....

Daily Medication (name of drug and frequency).....

### DECLARATION

I assume responsibility for any medical bills which may be incurred. I further release Wallingford Lacrosse Club, US Lacrosse and/or their representatives from responsibility for any problems that might arise as a result of medical care and or treatment.

Parent /Guardian Signature ..... Date: .....