



MILFORD YOUTH LACROSSE

PARENT / GUARDIAN CONSENT AND MEDICAL RELEASE

Player Information

Player Name: _____ **DOB:** _____ **Gender:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Emergency Contacts

Parent/Guardian Name: _____ **Relationship:** _____
Home Number: _____ **Cell Number:** _____ **Work Number:** _____
Parent/Guardian Name: _____ **Relationship:** _____
Home Number: _____ **Cell Number:** _____ **Work Number:** _____

When Parent/Guardian(s) cannot be reached, please contact:

Name: _____ **Relationship:** _____
Home Number: _____ **Cell Number:** _____ **Work Number:** _____

Medical Information

Players Physician: _____ **Physician Phone:** _____
Players Dentist: _____ **Dentist Phone:** _____
Hospital Preference: _____
Date of last tetanus booster: _____
Known allergies: _____
Known medical conditions: _____
Other: _____

Insurance Information

Name of Insured: _____ **Relationship to Player:** _____
Insurance Carrier: _____ **Policy #:** _____ **Group #:** _____

Recognizing the possibility of injury or illness, and in consideration for Milford Youth Lacrosse and members of Milford Youth Lacrosse accepting my son/daughter as a player in the lacrosse programs and activities of Milford Youth Lacrosse and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify Milford Youth Lacrosse, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of lacrosse. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer (coach) and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

Signature of Parent or Guardian

Printed Name

Date