**Bedford Youth Lacrosse**
**CONSENT TO TREAT**

This is to certify that on this date, I _____, as parent or guardian of _____, give my consent to Bedford Youth Lacrosse and its representative as members of US Lacrosse to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned athlete, for any injury that could arise from participation in US Lacrosse sanctioned events. If said athlete is covered by any insurance company, please complete the following:

Insurance Company: _____ Policy Number: _____

Signed: _____ Relationship to Athlete: _____

Home Address: _____ Phone: (____) _____

## MEDICAL HISTORY

**WHO TO CONTACT IN CASE OF AN EMERGENCY?**

Name: _____ Relationship: _____
Daytime Phone: _____ Evening Phone: _____
Physician's Name: _____ Phone: _____

**PLEASE COMPLETE THE FOLLOWING:**

If the answer to any of the following questions 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?

**Circle One**

| | | |
|---|---|---|
| Head injury (concussion, skull fracture) | Yes | No |
| Fainting spells | Yes | No |
| Convulsions/epilepsy | Yes | No |
| Neck or back injury | Yes | No |
| Asthma | Yes | No |
| High blood pressure | Yes | No |
| Kidney problems | Yes | No |
| Hernia | Yes | No |
| Diabetes | Yes | No |
| Heart murmur | Yes | No |
| Allergies | Yes | No (specify) |

**Injuries to:**

| | | |
|---|---|---|
| Shoulder | Yes | No |
| Knee | Yes | No |
| Ankle | Yes | No |
| Fingers | Yes | No |
| Arm | Yes | No |

**Other:**

| | | |
|---|---|---|
| Impaired vision | Yes | No |
| Impaired hearing | Yes | No |

**Other:**

| | | |
|---|---|---|
| Have you had a recent tetanus booster? | Yes | No (if so, when?) |
| Are you currently taking any medications? | Yes | No (If so, what / why?) |
| Has the doctor placed any restrictions on your activity? | Yes | No (if so, why) |

Parent Signature: _____ Date: _____