West Haven Youth Lacrosse Medical Release Form

The purpose of this form is two-fold:

1. **To obtain parent or guardian permission for a coach to seek medical treatment for a player in the event that such treatment is required and when a parent or guardian cannot be contacted.**
2. **To collect information that will help to ensure medical personnel has necessary details of any medical conditions, which may interfere with or alter treatment**.

Player Name _____ **DOB** (dd-mo-yyyy)_____

Family Physician _____ **Physician Phone** _____

Physician Address _____ **Hospital Preference** _____

Dentist _____ **Dentist Phone** _____

In case of emergency contact:

Name	**Phone number (s)**	**Relationship to player**
Name	**Phone number (s)**	**Relationship to player**

Date of last tetanus booster:_____
Known allergies incl. medicines _____
Known medical problems _____
Other _____

Person responsible for payment of medical bills and fees:

Name	**Relationship to Player**	**Home Ph**	**Other Ph**
Address	**Insurance Carrier**	**Policy #**	

I _____ **(Parent/Guardian's Name) hereby authorize my child**_____ **(Child's name) to be treated by medical personnel (e.g., EMT, First Responder, E.R. Physician). In the event of an accident, injury, or other medical emergency during team functions when I cannot be contacted.**

Signature of Parent/Guardian _____**Date**_____