

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.

Note: This information is to be carried by the team manager or coach to each team function together with team roaster and other team-related information. This information will be discarded at the end of the season.

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

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

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 _____