

**US LACROSSE PARTICIPANT MEDICAL EMERGENCY CARD**

Player Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate Mo: \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_  
Age as of January 1<sup>st</sup> \_\_\_\_\_  
Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_  
Father's Employer \_\_\_\_\_  
Father's Daytime Phone \_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Mother's Employer \_\_\_\_\_  
Mother's Daytime Phone \_\_\_\_\_  
Family Doctor \_\_\_\_\_  
Doctor's Phone \_\_\_\_\_  
Special information regarding medical history:

Person to notify if parents can't be reached:

Name \_\_\_\_\_  
Daytime phone \_\_\_\_\_  
Name \_\_\_\_\_  
Daytime phone \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENT TO MEDICAL TREATMENT:**

If the above named participant needs emergency medical treatment and neither parent nor the family doctor can be reached, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

Signature of Parent/Guardian

Print Name

Date

