MEDICAL RELEASE FORM

PARENT: COMPLETE THIS FORM AND RETURN TO YOUR PLAYERS TEAM MANAGER AND/OR COACH
TEAM MANAGER/COACH: A PRINTED COPY OF THIS FORM MUST BE STORED IN THE COACHES BOX AND PRESENT AT ALL LW LACROSSE ACTIVITIES. IN THE EVENT EMERGENCY, MEDICAL CARE IS REQUIRED, THIS FORM MUST ACCOMPANY THE PLAYER TO THE MEDICAL FACILITY.

PERSONAL INFORMATION

PLAYER NAME

BIRTHDATE

PRIMARY CONTACT

MOBILE

SECONDARY CONTACT

MOBILE

ADDRESS

CITY, STATE ZIP

PHYSICIAN NAME

PHONE

LOCAL HOSPITAL PREFERENCE

INSURANCE CARRIER

ID#

MEDICAL HISTORY

ALLERGIES

PRESCRIPTIONS

DRUG ALLERGIES

LAST TETANUS BOOSTER DATE

DOES PLAYER HAVE ANY CONDITION THAT COULD POTENTIALLY LIMIT HIS/HER PHYSICAL ABILITY OR INCREASE RISK OF INJURY AS A RESULT OF PARTICIPATING IN ATHLETIC ACTIVITIES? YES ☐ NO ☐ PLEASE EXPLAIN:

PARENTS CONSENT

As the parent or legal guardian of the above registered participant, I request that, in my absence, the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

I certify that the information provided above is true and accurate to the best of my knowledge.

SIGNATURE

Date