

Metro Lacrosse League Emergency Medical Form

Student Name _____

Date of Birth ___/___/_____

Parent/Guardian Name _____

Home Address _____

City _____ State _____ ZIP _____

Telephone _____ Nighttime _____

If person named above is not available in the event of an emergency, notify:

Name _____ Relationship _____ Telephone _____

Personal Physician Name _____ Telephone _____

Health Insurance Carrier _____ Policy# _____

Does the student have any of the following medical conditions?

Asthma _____ Heart Disease _____ Hemophilia _____

Allergies _____ High Blood Pressure _____ Other _____

Diabetes _____ Epilepsy _____

Explanations: _____

Is the student allergic to any medications? Yes/ No

Explanations: _____

Any reason to restrict the students full participation in Lacrosse? Yes/ No

If Yes, please explain: _____

In case of emergency, I understand every effort will be made to contact me. In the event I can not be reached, I hereby give my permission for a licensed physician to administer proper treatment including hospitalization, x-rays, laboratory tests, anesthesia, surgery, and/or medications for my child.

Parent/Guardian Signature _____ Date ___/___/_____
