US LACROSSE PARTICIPANT MEDICAL EMERGENCY CARD

Player Name _____
Address _____
City _____
State _____ Zip _____
Birthdate Mo: _____ Day _____ Yr _____
Age as of January 1st _____
Home Phone _____

Person to notify if parents can't be reached:
Name _____
Daytime phone _____
Name _____
Daytime 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:
_____
_____
_____
_____

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

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