US LACROSSE PARTICIPANT MEDICAL EMERGENCY CARD

Player Name _____

Address _____

City _____ State _____ Zip _____

Birthdate Mo: _____ Day _____ Yr _____ Age as of January 1, 2010 _____

Home Phone _____

Father's Name _____

Father's Employer _____ Father's Daytime Phone _____

Mother's Name _____

Mother's Employer _____ Mother's Daytime Phone _____

Person to notify if parents can't be reached:

Name _____ Daytime phone _____

Name _____ 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