

Arlington Youth Lacrosse Club

Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I/We are the parent(s)/guardian(s) of _____

Subject to the conditions set forth below, I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's (children's) participation in any activity sponsored by the Arlington Youth Lacrosse Club.

Should a medical emergency arise during my child's participation in an Arlington Youth Lacrosse Club sponsored activity. I understand that reasonable efforts will be made to contact me or my designated alternate at the phone number listed below. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to:

- (i) the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Arlington Youth Lacrosse Club; and
- (ii) the immediate administration of life-sustaining measure deemed necessary under the circumstances.

Health Information

The following information may be needed by a medical doctor and/or medical facility not having access to your child's medical history:

Allergies: _____

Medicine being taken: _____

Date of last tetanus shot: _____

Physical Impairments: _____

Other pertinent facts to which a medical doctor should be alerted:

Other pertinent information Coach should know about your child: _____

Insurance Information

Company: _____ Policy Number: _____

Policyholder's Name: _____

Father's/Guardian's Name: _____

Mothers/Guardian's Name: _____

Address: _____

Address: _____

Daytime Phone: _____

Daytime Phone: _____

Evening Phone: _____

Evening Phone: _____

Cell Phone: _____

Cell Phone: _____

If I cannot be reached in the event of an emergency, the following person is authorized to act on my behalf (designated alternate): _____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Relationship: _____

Preferred Medical Doctor / Medical Facility: _____

Daytime phone: _____ Evening Phone: _____

Signature of Parent or Guardian

Date

SEPARATED FROM REGISTRATION MATERIALS AND KEPT BY THE COACH ON THE FIELD.