

Indiana Area Lacrosse

Summer Lacrosse Camp - Player Medical Information and Release Form

Player's Name: _____ Date of Birth: ___/___/___

Address: _____ City, State, Zip: _____

Name of Parent/Guardian Home Phone Work Phone Cell Phone E-mail

Father: _____

Mother: _____

In an emergency, when parents cannot be reached, contact:

Name Home Phone Work Phone Cell Phone

First: _____

Second: _____

Allergies to Medications: _____ Other Allergies: _____

Asthma? Yes / No

Heart Trouble? Yes / No

History of Concussions? Yes / No

Epilepsy? Yes / No

Contacts/Glasses? Yes / No

Diabetes? Yes / No

Other Medical Conditions: _____

Information/limitations related to the above conditions that coaches may need to address the conditions or provide to medical providers: _____

_____ (if necessary, put additional info on the reverse side and check here ___)

Player's Physician: _____

Name

Office Phone

Home Phone (if available)

Player's t-shirt size (circle one): Adult S, M, L, XL or Youth S, M, L, XL

Will your grade school player be BRINGING a lacrosse stick to camp? Yes / No

Player's US Lacrosse Membership #: _____, effective from _____ to _____.
(US Lacrosse Membership, which provides insurance, is required. Go to www.uslacrosse.org to register.)

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the potential for physical injury resulting from participating in lacrosse and related programs and activities (the "Programs"), and in consideration for IA LAX accepting my son/daughter for participation in the Programs, I hereby assume on behalf of my child the risk of such injury, and hereby release, discharge and/or indemnify IA LAX, its coaches, volunteers, board of directors, affiliated organizations, and sponsors, including the owners of fields and facilities utilized for the Programs, of, from and against any claim by or on behalf of my child for injuries related to his/her participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize. _____ (Initial)

My child received a examination by a physician and was found to be physically capable of participating in the Programs. (IA LAX reserves the right to require written authorization from the physician.) _____ (Initial)

I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with emergency medical assistance and/or treatment and agree to be financially responsible for the reasonable cost related thereto. _____ (Initial)

_____/_____/_____
Signature of Parent/Guardian Date Print Name