Upstate Lacrosse Association – U.L.A. Inc.

Authorization for Medical Treatment of Minors

Name of Minor: _____

Date of Birth: _____

Identify Allergies or Special Conditions:

_____

_____

Parent Name (print): _____

Address: _____

_____

I/We, being the parent(s) or legal guardian(s) of the above-named minor, do hereby appoint,

Coach: _____

Coach: _____

to act in my/our behalf in authorizing unexpected medical, surgical care, and/or hospitalization for the above-named minor during the period of my/our absence.

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent/Guardian Signature: _____

Date: _____ Phone: _____

Witness Signature: _____

Date: _____ Phone: _____

Insurance Company I.D. or Contract Number: _____

Hospital Coverage for the Above-named Minor: _____

Family Physician: _____ Phone: _____