

**SPRINGFIELD YOUTH CLUB LACROSSE  
AUTHORIZATION FOR EMERGENCY TREATMENT**

I, \_\_\_\_\_, authorize any physician,  
(Parent or Guardian)

in the case of an emergency, to render medical treatment, which in his/her judgment may be deemed necessary in the care of \_\_\_\_\_.  
(Player)

**PLAYER'S MEDICAL INFORMATION**

Name of Physician \_\_\_\_\_

Physician's telephone number \_\_\_\_\_

Allergies \_\_\_\_\_

Current medications \_\_\_\_\_

Date of last physical \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Brief medical history (diabetes, heart disease, asthma, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

Identification/Policy No. \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Place of Employment \_\_\_\_\_

Insured's Telephone No. \_\_\_\_\_

NOTE: Head Coaches or Team Parents are responsible for maintaining this form and making it available to the hospital medical personnel.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Cellular (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_