Northland Lacrosse Club 2015 Medical Form

Name: Parents:

Address: Phone:

Birth date: Age as of 12/31/14: Height: Weight:

Emergency Contact Names and Numbers:

Mother's Cell: Mother's work:

Father's Cell: Father's work:

Family Doctor: Doctor's phone number:

Family Dentist: Dentist phone:

Other emergency contact: Phone number:

Hospital preference:

List any injuries or illnesses within the last year:

List any allergies:

List any medications you take/dosage:

In the event of an emergency, I authorize medical treatment for my son/daughter and release the Northland Lacrosse Club from responsibility for any injuries in the course of practices or games.

Parents Signature: ________________________ Print Name: ________________________________ Date: ___________________

PROOF OF INSURANCE:

Primary Insurance Carrier: Effective Date:

Policy Number: Policyholder's name: Policyholder's D.O.B.

Policyholder's Employer:

Secondary Insurance Carrier: (if applicable) Effective Date:

Policy Number: Policyholder's name: Policyholder's D.O.B.

Policyholder's Employer:

Insurance Requirements: The player named above understands and agrees that primary medical insurance coverage is required to be provided by the player for the period from the execution of Proof of insurance until December 31, 2015 in conjunction with the player's participation in any field or indoor lacrosse playing activities (including, without limitation to, practices, scrimmages, and league regular-season, playoff, tournament and all-star games).

Change in Insurance Status: In the event that the Player's primary medical insurance coverage terminates during this period, the player agrees to immediately withdraw from participation in all playing activities and notify his/her club of change in insurance issues.

Failure to provide insurance: No member club may permit any Player to participate in any lacrosse playing activity activities (including, without limitatio n to, practices, scrimmages, and league regular-season, playoff, tournament and all-star games) until and unless the League/Association/Team has received proof of insurance in accordance with its rules and regulations.

I acknowledge and agree to these terms and conditions.

Player's Name: ____

Player's Signature: ____ Date: ______________________________

Parent's Signature: ____ Date: ______________________________

Insurance Company authorization: I authorize the above insurance company to provide the League/Association/Team with all information necessary to verify my medical insurance coverage.

Name of insured: ____ Date: ________________________________