US LACROSSE PARTICIPANT MEDICAL EMERGENCY CARD

Player Name ____
Address ____
City ____
State ______________________________ Zip ______________
Birthdate Mo: ___________ Day ___________ Yr ___________
Age as of January 1st ____________________________________
Home Phone ____

Person to notify if parents can't be reached:
Name ____
Daytime phone ____
Name ____
Daytime phone ____

Father's Name ____
Father's Employer ____
Father's Daytime Phone ______________________________________
Mother's Name ____
Mother's Employer____
Mother's Daytime Phone ______________________________________
Family Doctor ____
Doctor's Phone ____
Special information regarding medical history:
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CONSENT TO MEDICAL TREATMENT:
If the above named participant needs emergency medical treatment and neither parent nor the family doctor can be reached, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

Signature of Parent/Guardian Print Name Date