Sylvan Lake Lacrosse Association Medical Form

Name: _____

Date of Birth: **Day**_____ **Month**_____ **Year**_____

Mailing Address: _____

Postal Code:_____ **Contact Number:**_____

Provincial Health Care Number:_____

Mothers Name:_____ **Cell:**_____

_____

Fathers Name:_____ **Cell:**_____

Person to contact in case of accident/emergency if parents are not available:

Name:_____ **Cell:**_____

Does your child have any previous history of concussions?_____

Does your child have any allergies? _____

Does your child have any health problems that would interfere with participation on the lacrosse team?

_____

Please give details below if you answered yes to any of the above items.

_____

_____

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible. In the even no one can be contacted, team management will take my child to the hospital if deemed necessary. I authorize the physician and nursing staff to undertake examination investigation and necessary treatment of my child. I also authorize release of information to appropriate people (team management, coach, physician) as deemed necessary.

Date:_____ **Signature of Parent:** _____