Upstate Lacrosse Association- U.L.A. INC.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAME OF MINOR_____ BIRTH DATE_____

IDENTIFY ALLERGIES OR SPECIAL CONDITIONS:
_____

_____
_____

I/WE, BEING THE PARENTS(S) OR LEGAL GUARDIANS(S) OF THE ABOVE NAMED MINOR, DO HEREBY APPOINT (THE COACHES NAMES GO HERE):
NAME ADDRESS
PHONE

1._____
_____

2._____
_____

TO ACT IN MY/OUR BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE NAMED MINOR(S) DURING THE PERIOD OF MY/OUR ABSENCE FROM:

For the 2020 ULA Season

THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTIST OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTIST, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED.

1.
_____
_____
PARENT GUARDIAN SIGNATURE ADDRESS PHONE

_____
_____
WITNESS SIGNATURE ADDRESS PHONE

HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S):

1.
_____
_____
INSURANCE COMPANY I.D. OR CONTRACT NUMBER

HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S):

2.
_____
_____
INSURANCE COMPANY I.D. OR CONTRACT NUMBER

FAMILY PHYSICIANS:

1. _____
_____
NAME AND NUMBER

FAMILY PHYSICIANS:

2. _____
_____
NAME AND NUMBER