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 2021 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.

1PARENT 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