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:
During the 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