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 2024 ULA Spring / Summer 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

2. _____

Parent Guardian 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