

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: **MONTH/DAY/YEAR** through **MONTH/DAY/YEAR**

5/1/10 through 8/1/10

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