



**St. Charles High School Boys Lacrosse Club  
2010 Medical Information & Emergency Treatment Release**

**A photocopy of the player's health insurance card  
(both sides) must be attached to this form.**

Player's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ School: StCE \_\_\_ StCN \_\_\_ Class of \_\_\_\_\_

Home Address \_\_\_\_\_

Tel: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

I (please circle:) have/ don't have allergies.

My allergy/ies (if any) are to: \_\_\_\_\_

I (please circle:) have /do not have a pre-existing or recent medical condition the club should be aware of, such as diabetes, a recent injury (ie, concussion), etc.

My condition (if any) is: \_\_\_\_\_

My primary physician is \_\_\_\_\_

Address \_\_\_\_\_ tel \_\_\_\_\_

My medical insurance is provided by \_\_\_\_\_  
(Name of insurance company)

Policy holder \_\_\_\_\_ Group/Policy no. \_\_\_\_\_

I, \_\_\_\_\_, the parent or guardian of player \_\_\_\_\_,

do hereby give permission for my son to receive emergency medical treatment in the event of an injury. I further give permission for the St Charles High School Boys Lacrosse Club officials to authorize emergency transportation to the nearest trauma center or emergency room for such treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_