



**St. Charles High School Boys Lacrosse Club
2011 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 _____