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 NEMED MINOR, DO HEREBY APPOINT:

NAME	ADDRESS	PHONE
1. JDYAA Lacrosse Coaching Staff		
2._____		
3._____		

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: **5/1/10 through 7/31/10**

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
2._____		
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

FAMILY PHYSICIANS:

1._____ 2._____

NAME AND NUMBER NAME AND NUMBER