

# 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:

5/1/14 Through 8/1/14

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