

PENN YAN YOUTH LACROSSE
EMERGENCY MEDICAL INFORMATION DATA
(TO BE FILLED OUT FOR EACH PLAYER, COACH)
P.O. Box 374, Penn Yan, NY 14527

Lacrosse Player _____

Boy or Girl _____

Current Grade _____

Address: _____

Birthdate ____/____/____

Jersey Size --- YS / YM / YL ** AS / AM / AL

Contact Information for Coaches:

First Contact Name _____

Second Contact Name _____

Email _____

Email _____

Phone Numbers _____

Phone Numbers _____

Cell Numbers _____

Cell Numbers _____

In Case of Emergency (when parents can't be reached)

Name _____

Doctor Information:

Doctor Name _____

Relationship to player _____

Doctor Phone Number _____

Phone Numbers _____

Health Ins. _____

Cell Numbers _____

Policy Number _____

Health or medical information of problems.(i.e. allergies, asthma, epilepsy, etc)

In the event we (I) cannot be reached in an emergency, we (I) hereby give permission to the physician, selected by the adult leader in charge, to hospitalize and provide all emergency medical treatment required, based on professional judgment of a licensed physician. Every effort will be made to contact you in case of any emergency.

Parent/Guardian Signature _____

Date: ____/____/____

Penn Yan Youth Lacrosse Use Only

Paid by: Check # _____

Cash _____