



2003 Under-19 World Championships

RELEASE FORM FOR MEDICAL AND/OR HOSPITAL TREATMENT

Ihereby grant permission for the properly designated U-19 World Championship Personnel to administer emergency care (on site or at St. Joseph's Hospital, Towson Maryland or other such facility) rendered to my child..... while he/she is under their supervision/care.

Parent's Name:

Address:

Telephone: (H)..... (W)..... Fax

Email:

MEDICAL INSURANCE COVER:

Name of Company and Policy Number:

RELATIVE OR FRIEND WHO MAY BE CONTACTED (list two)

Name	Relation	Phone Number	Email
.....

Name	Relation	Phone Number	Email
.....

MEDICAL HISTORY: (Fill in the blanks where applicable)

Known Allergies
Epilepsy/Seizures Diabetes.....
AsthmaBee Sting sensitivity.....
Relevant Medical/Surgical History.....
Daily Medication (name of drug and frequency).....

DECLARATION

I assume responsibility for any medical bills which may be incurred. I further release the IFWLA and or ILF, US Lacrosse and/or their representatives from responsibility for any problems that might arise as a result of medical care and or treatment. This includes Towson Sports Medicine, Orthopedic Associates, St. Joseph's Hospital Staff and US Lacrosse Staff.

DATE:

Parent /Guardian Signature