# VIRGINIA UNITED GIRLS LACROSSE
## YEAR _____

**EMERGENCY CARE INFORMATION**

PLAYER NAME _____

PLAYER DOB _____

DOCTOR NAME _____

DR PHONE NUMBER _____

KNOWN ALLERGIES (food/medicine) _____

KNOWN MEDICAL CONDITIONS (if any) _____

PARENT(S) NAME(S) _____

ADDRESS _____

CITY / STATE / ZIP _____

HOME PHONE _____ MOM WK _____ DAD WK _____

MOM CELL _____ DAD CELL _____

**INSURANCE INFORMATION**

INSURANCE COMPANY _____

INS PHONE NUMBER _____

IDENTIFICATION / POLICY NUMBER _____

SUBSCRIBER NAME _____

SUBSCRIBER'S CELL NUMBER _____

**IN CASE OF EMERGENCY**

CONTACT NAME _____

RELATIONSHIP _____

CONTACT ADDRESS _____

CITY / STATE / ZIP _____

CONTACT PHONE _____

CONTACT CELL _____

**I hereby authorize any physician and/or any member of the Medical Staff of any emergency medical facility requested by the physician, to medical treatment, which may be deemed necessary in the care of my child.**

Signature (parent or guardian) _____

Date _____