BLUE WAVE WEST YOUTH LACROSSE ORGANIZATION, INC.
UPSTATE LACROSSE ASSOCIATION

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Minor: _____

Birth Date: _____ 2020/2021 Grade: _____

Allergies/Special Conditions: _____

I/We being the parent(s)/legal guardians of the above named minor do hereby appoint:
NAME ADDRESS PHONE Number(s)

1. _____

2. _____

To act in my behalf in authorizing unexpected medical treatment, surgical care and/or hospitalization for the above named minor(s) during the period of my absence from:

MONTH/DAY/YEAR: _____ THROUGH MONTH/DAY/YEAR: _____

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medial, dentist, surgical care or hospitalization may be required.

_____
Parent/Guardian Signature

_____
Address Phone

_____
Witness Signature Witness Name

_____
Address Phone

_____
Insurance Company for above named minor ID/Contract No.

_____
Family Physician(s) Phone

_____
Address