

ROCK BRIDGE LACROSSE

Definitive Emergency Medical Care Consent

I (We), the undersigned parent(s) or Legal Guardian(s) of

Player's Name

Do hereby consent to have prompt and definitive emergency medical care administered to the aforementioned member of my (our) family in my (our) absence. In doing so, I (we) release the administering facility and/or individual from responsibility for medical services performed.

Rock Bridge Lacrosse, Inc., its members, officers, directors and coaches, and/or its team members and representatives are hereby resolved from responsibility for subsequent consequences occurring therefrom. If deemed medically necessary, please contact my (our) son's doctor.

Doctor's Name

Phone: _____

After Hours: _____

Hospital Preference

Date

Signature of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian

If we cannot be reached, in case of emergency call:

Name/Relationship

Phone Number

Please list any important medical information, medications or allergies regarding your son: