



# Homestead Lacrosse

2023 - 2024 Season | Medical Information & Release Form

**Homestead Lacrosse Coaching staff must have this form physically present at all practices & games.**

<b>ATHLETE NAME</b>				<b>DATE OF BIRTH</b>	
last, first, and middle initial				mm/dd/yyyy	
<b>FATHER'S NAME</b>			<b>EMAIL</b>		
<b>HOME PH#</b>		<b>MOBILE</b>		<b>WORK PH#</b>	
xxx-xxx-xxxx		xxx-xxx-xxxx		xxx-xxx-xxxx	
<b>MOTHER'S NAME</b>			<b>EMAIL</b>		
<b>HOME PH#</b>		<b>MOBILE</b>		<b>WORK PH#</b>	
xxx-xxx-xxxx		xxx-xxx-xxxx		xxx-xxx-xxxx	
IF PARENTS ARE DIVORCED WHO IS THE CUSTODIAL PARENT (MOTHER?, FATHER?, JOINT?)					
IF PARENT(S) ARE NOT AVAILABLE, EMERGENCY CONTACT?					
<b>CONTACT NAME</b>				<b>PREFERRED PH#</b>	

## Athlete medical information

<b>PRIMARY CARE MD</b>			<b>OFFICE PH#</b>		
<b>ADDRESS</b>					
	street address with suite#		city	state	zip
<b>MEDICAL CONDITIONS</b>				<b>MEDICAL ALERT</b>	
			<b>INHALER?</b>	yes <input type="checkbox"/>	no <input type="checkbox"/>
			<b>EPI-PEN?</b>	yes <input type="checkbox"/>	no <input type="checkbox"/>
<b>PRESCRIPTION MEDICATIONS</b>			<b>DIABETIC?</b>	yes <input type="checkbox"/>	no <input type="checkbox"/>
<b>ALLERGIC TO MEDICATION(S) PLEASE LIST</b>					

## Athlete medical insurance

<b>POLICYHOLDER</b> (AS LISTED ON MEDICAL PLAN ID CARD)		
<b>MEDICAL PLAN CARRIER</b>	<b>POLICY#</b>	

\_\_\_\_\_  
Athlete's name (print)

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
mm/dd/yyyy

\_\_\_\_\_  
Parent/legal guardian name (print)

\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
mm/dd/yyyy

\_\_\_\_\_  
Parent/legal guardian name (print)

\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
mm/dd/yyyy

**WARNING: Protective equipment cannot prevent all injuries an athlete may receive while participating in athletic activities.**

Email completed/signed form to: [homesteadboyslacrosseclub@gmail.com](mailto:homesteadboyslacrosseclub@gmail.com)