

**TOTAL LACROSSE ELITE
REGISTRATION AND HEALTH FORM**

Name of athlete _____ Age of athlete _____

Address _____
(Street address) (City) (Zip code)

Home Telephone _____ Cell Phone _____

Mother's Work Telephone _____ Father's Work Telephone _____

E-mail Address _____

Emergency Contact Person and Relationship _____

Emergency Contact Telephone _____

Is the athlete covered by family medical/hospital insurance?(Please circle) Yes No

If so, indicate the carrier or plan name _____ Policy # _____

Name of insured _____

If the athlete should be restricted from any activities (running, contact drills, etc.), please

note: _____

If the athlete will be taking medication during camp, please indicate the condition, the name of drug and

dosage: _____

Please indicate any medical conditions (asthma, glasses, allergies, etc.) or history which would require special

attention: _____

Please indicate any other information that our staff may need to know about your child to help make our camp

experience more enjoyable: _____

I give my permission for my child to receive routine medical treatment, emergency medical or surgical treatment, and hospitalization if necessary. I understand that every attempt will be made to contact me, or the named emergency contact, before taking any action. I hereby waive and release the Total Lacrosse Camp staff and management from any liability for any injury or illness incurred while at camp. **I UNDERSTAND, BEING THAT LACROSSE IS A CONTACT SPORT, THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY.** I will be financially responsible for any medical attention needed during camp.

Parent's signature

Date

