CONSENT TO TREAT

This is to certify that I, _____, as parent or guardian of _____ (athlete participant), or for myself as an adult participant, give my consent to Ballistic Sports Group, Inc., US Lacrosse, and their medical representative(s) to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in Ballistic sports Group, Inc., and/or US Lacrosse events.

If said participant is covered by any insurance company, please complete the following:

Name of Insurance Company: _____

Address: _____

Policy Number: _____

Signed: _____ Dated: _____

Parent/guardian or adult participant

Relationship to Athlete: _____

Home Address: _____

Phone: (_____)_____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name: _____

Daytime Phone: _____ Evening Phone: _____

Hospital of Choice: _____

FORM CONTINUES ON BACK

MEDICAL HISTORY FORM

(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)

Name: _____ Date: _____

Address: _____

Birthdate: _____

Daytime Phone: _____ Evening Phone: _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following? Circle One

Head injury (concussion, skull fracture) Yes \No

Fainting spells Yes No

Convulsions/epilepsy Yes No

Neck or back injury Yes No

Asthma Yes No

High blood pressure Yes No

Kidney problems Yes No

Hernia Yes No

Diabetes Yes No

Heart murmur Yes No

Allergies Yes No Please specify: _____

Injuries to:

Shoulder Yes No

Knee Yes No

Ankle Yes No

Fingers Yes No

Arm Yes No

Impaired vision Yes No

Impaired hearing Yes No

Other: _____

Are you currently taking any medications? _____ What? Why? _____

Has the doctor placed any restrictions on your activity? _____ Explain: _____

_____