Adrenaline Lacrosse Medical and Insurance Information
This form is required for participation.

MAIL TO:
Adrenaline Lacrosse-Medical Information
4060 Morena Blvd. Suite L
San Diego, CA 92109

EVENT ATHLETE WILL BE ATTENDING:
____

Athlete Information
Last Name: ______________________________ First Name: ____________________________________
Gender: M/F DOB: ______/______/______ Age: ______ SSN: ______-______-______
Address _________________________________ City _____________________________ Zip _________

Emergency Contact

Name: __________________________________
Relation: ________________________________
Home Phone: (______) ______-____________
Work Phone: (______) ______-____________
Cell Phone: (______) ______-____________

Name: __________________________________
Relation: ________________________________
Home Phone: (______) ______-____________
Work Phone: (______) ______-____________
Cell Phone: (______) ______-____________

Insurance Information
Subscriber's Name: ____
Policy/Group No.: ________________________ SSN: ______-______-______
Insurance Co. Name: ____
Address: ____ Phone Number: (____) ______-______
Type of Insurance: HMO, PPO, POS, Other: ____
Primary care physician: _________________________________ Phone Number: (____) ______-______

Health History
If you answer yes to any of the questions below, please explain in detail.

1. Is the athlete currently under a doctor's care? Y/N
   a. If yes, please state athlete's limitations, if any, and what to do in the event of an emergency.
2. Has the athlete recently had surgery or been hospitalized? Y/N
3. Does the athlete currently have any medical injuries or illnesses? Y/N
   a. If yes, please state athlete's limitations, if any, and what to do in the event of an emergency.
4. Is the athlete currently taking any medications, including medications used only during a medical emergency? Y/N
   a. If yes, please specify the medication(s) and what to do in the event of an emergency.
5. Does the athlete have any dietary restrictions? Y/N
6. Does the athlete have any allergies? Y/N

    a. If yes, please state what to do in the event of an emergency.
7. Does the athlete have asthma? Y/N
    a. If yes, please state what to do in the event of an emergency.
8. Does the athlete have any other condition(s) that may affect participation or care if injured? Y/N

Over-the-counter medications
Please indicate the OTC (generic forms) you authorize the staff to administer as needed:

- Acetaminophen Y/N
- Ibuprofen Y/N
- Cough Drops Y/N
- Benadryl Y/N
- Pepto-Bismol Y/N
- Sudafed Y/N

Authorization for Treatment
The information provided is correct, and the person herein described has permission to engage in all Adrenaline Lacrosse activities as noted. I hereby give permission to the medical personnel selected by Adrenaline Lacrosse to evaluate any injuries/illnesses, administer first-aid, and make referrals for further care as deemed necessary. In the event I cannot be reached in an emergency, I hereby grant permission to Adrenaline Lacrosse medical staff and providers to secure and administer treatment, including hospitalization for the above specified person. I agree to pay for any costs related to medical treatments that are not covered by insurance or if I have no medical insurance.

Parent/Guardian/Adult Athlete Name: ________________________
Parent/Guardian/Adult Athlete Signature: _____________________ Date: _______/_____/______