Carmel Girls Lacrosse
EMERGENCY MEDICAL INFORMATION

The following information is very important in order to assure your student athlete of prompt medical care in case of injury. **Please provide complete and legible information**.

____ ______________
Student Last Name, First Name, Middle Name Date of birth

____ ______________
Student Address (street, city, zip) School Grade 2011-12

____ ______________________
Student Email(s) Home Phone #

____
Father's Name Address (street, city, zip) Home Phone #

____
Mother's Name Address (street, city, zip) Home Phone #

____
Father's Employment Work Phone # and/or Cell Phone # Father's email(s)

____
Mother's Employment Work Phone # and/or Cell Phone # Mother's email(s)

If parents divorced or separated, who is the custodial parent: _____Mother _____Father _____Joint

If not parent(s), person with whom student is living: ____
Last Name, First Name

____
Address (street, city, zip) Phone # relationship

In case of emergency, **if parent is not available**, please contact:

____
Name Phone #

____
Family Physician Office Phone # Emergency Phone #

I/we authorize responsible CGL personnel to oversee or provide emergency medical care to participant in the event of serious injury.
CGL representatives may administer the following **ANALGESIC** and/or **BEE STING MEDICATION:**

YES	NO	
_____	_____	Acetaminophen (Tylenol or generic)
_____	_____	Ibuprofen (Advil, Nuprin, Motrin, or generic)
_____	_____	Diphenhydramine HCl/Benadryl by mouth if stung by a bee or wasp
_____	_____	Does your child use an inhaler?
_____	_____	Is athlete allergic to any medications? If yes, please specify:____________________________

PARENT/LEGAL GUARDIAN SIGNATURE (X)_________________________________ DATE___________

Revised 11/1/2011