

# Looney's Lacrosse Club

## Player Participation Form

(PLEASE bring a completed and signed Player Participation Form along with your \$20.00 Fee to tryouts.)

### PLAYER INFORMATION

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Years Experience: \_\_\_\_\_ Other Clubs Played for: \_\_\_\_\_

Positions:  Goalie  Defense  Midfield  Attack

U.S. Lacrosse Membership Number: \_\_\_\_\_

US Lacrosse Number can be obtained and/or renewed from: [www.lacrosse.org](http://www.lacrosse.org) / 410-235-6882

### PARENT EMERGENCY CONTACT INFORMATION

Father's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\*E-Mail: \_\_\_\_\_

\* Most of the communication will be done via e-mail so this is a mandatory field.

### HIGH SCHOOL 9-12

Will you have any regular scheduling conflicts with other activities?  Yes  No

Please describe High School program conflicting activities: \_\_\_\_\_

### MEDICAL RELEASE

Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Does your child have any medical problems such as: seizures, drug allergies, nose bleeding, unusual reaction to insect bites, asthma or diabetes?  Yes  No

If Yes, please list: \_\_\_\_\_

Does your child take any medications on a regular basis?  Yes  No

If Yes, please list: \_\_\_\_\_

As evidenced by my signature below, I hereby acknowledge that my daughter \_\_\_\_\_ is physically able to participate in competitive lacrosse and that I know of no restrictions, physical impairments, or any other facts which in any manner limit her participation in such a program.

I give permission for my child to receive emergency medical or surgical treatment and hospitalization if necessary. I hereby authorize \_\_\_\_\_ to consent to medical treatment for my child, including consent to the transportation of the child. I understand that every attempt will be made to contact me before taking this action.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### PROOF OF PRIVATE INSURANCE

Insurance Company: \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No.: \_\_\_\_\_