

# PALO VERDE LACROSSE CLUB

www.paloverdelacrosse.com

Check One:

Date: \_\_\_\_\_

- PVHS Mens "PANTHERS"
- Middle School Boys "ROUGHRIDERS"
- PVHS Girls "PANTHERS" (Grades 7-12)

As of today, your player is registered with: (Yes or No)

- US Lacrosse
- Southern Nevada Lacrosse Association
- Palo Verde Lacrosse Club

Player Name: \_\_\_\_\_

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

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

Age/Date of Birth: \_\_\_\_\_

School/Grade: \_\_\_\_\_

Player's Cell Phone: \_\_\_\_\_

Player's Email: \_\_\_\_\_

Uniform Size: Jersey: \_\_\_\_\_ Shorts: \_\_\_\_\_ I have a uniform: \_\_\_\_\_

(YS, YM, YL, MS, MM, ML, MXL, MXXL)

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Other Phone Numbers: (Work, Cell etc.) \_\_\_\_\_ Other Emails: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Non-Custodial Parent Information (If Applicable):

\_\_\_\_\_

\_\_\_\_\_

I Will Volunteer for the Following:

Team Parent: \_\_\_\_\_ Score Keeper / Timers: \_\_\_\_\_

Team Pictures / Awards: \_\_\_\_\_ Other: \_\_\_\_\_

Sponsorship / Financial Donation: \_\_\_\_\_

**PARENTS:**

Lacrosse is a physically demanding contact sport. A physician, prior to participation, should evaluate all players. After clearance to participate from your physician, please fill out the **Medical Emergency Card** below. This card is for coaches and team officials only. Your signature below indicates not only consent for treatment, but acknowledges to the Palo Verde Lacrosse Club that your child has been found by a physician to be suited to the physical demands of the sport. Any medical conditions disclosed below will be held in strict confidence by coaches and other officials of the Palo Verde Lacrosse Club.

**US LACROSSE PARTICIPANT MEDICAL EMERGENCY CARD**

Player Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: M: \_\_\_\_\_ D: \_\_\_\_\_ Y: \_\_\_\_\_ Age as of January 1<sup>st</sup>: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

**PERSON TO NOTIFY IF PARENTS CAN'T BE REACHED:**

Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

**SPECIAL INFORMATION REGARDING MEDICAL HISTORY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENT TO MEDICAL TREATMENT:**

If the above named participant needs emergency medical treatment and neither parent nor the family doctor can be reached, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date