



ATHLETE'S MEDICAL INFORMATION AND AUTHORIZATION

Athlete's Name: _____ Birth Date: _____

Parent/Guardian's Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Parent's Cell Phone: (____) _____ Parent's E-mail : _____

Physician's Name: _____ Physician's Phone: (____) _____

Insurance Co: _____ Policy #: _____

***It would be helpful to pack a copy of your child's insurance card with them on the trip.**

THE FOLLOWING STATEMENT MUST BE COMPLETED WITH A SIGNATURE AND DATE

In case of emergency, when I can not be reached, Virginia Swimming Inc., and any representative thereof, including the Team Manager, chaperone, or coach, has my permission to take the athlete named above, to any hospital, and the hospital staff and its medical staff have my permission to provide treatment which a physician deems necessary for the well being of the above named athlete.

Signature: (Athlete's Parent/Guardian) _____ Date _____

YOU MUST FURNISH THE NAMES OF MEDICATION AND ALLERGIES AND INTIAL AND DATE EACH ENTRY

ALL MEDICATION THE ABOVE ATHLETE IS PRESENTLY TAKING:

INITIALS _____ DATE _____

Please List ANY ALLLERGIES- FOOD, DRINK, MEDICINE, DRUGS, FEATHERS ETC.

INITIALS _____ DATE _____

This form can be completed on your computer and then printed.