

**VSI MEDICAL INFORMATION
ATHLETE
ATHLETE'S MEDICAL AUTHORIZATION**

Athlete's Name: _____ **Birthdate:** _____

Parent/Guardian's Name: _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Email :** _____

Physician's Name: _____ **Physician's Phone:** _____

Insurance Co: _____ **Policy #:** _____

**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 EACH ENTRY AND DATE**

ALL MEDICATION THE ABOVE ATHLETE IS PRESENTLY TAKING:

INITIALS _____ **DATE** _____

ANY ALLLERGIES TO FOOD, DRINK, MEDICINE OR DRUGS:

INITIALS _____ **DATE** _____

RETURN TO: **Pam Parrish**
 13317 Rollingwood Lane
 Montpelier, VA 23192