

**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 #: _____

*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 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:
Caycee Buscaglia
12711 Walton Ridge Lane
Midlothian, Virginia 23114