VSI MEDICAL INFORMATION ATHLETE ATHLETE'S MEDICAL AUTHORIZATION

Athlete's Name: Birthdate:				
Parent/Guardian's N	ame:			_
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 c	ard with them on the trip.	
		STATEMENT MUS SIGNATURE AN	ST BE COMPLETED D DATE	
thereof, including the above, to any hospita	e Team Manager, chap ll, and the hospital staf	erone, or coach, ha f and its medical st	mming Inc., and any representates my permission to take the ath aff have my permission to proving of the above named athlete.	lete named
Signature: (Athlete's	Parent/Guardian)		Date	
YOU M		NAMES OF MED AL EACH ENTRY	ICATION AND ALLERGIES AND DATE	
ALL MEDICATION	THE ABOVE ATHL	ETE IS PRESENT	LY TAKING:	
INTIALS	DATE			
ANY ALLLERGIES	TO FOOD, DRINK, N	MEDICINE OR DE	RUGS:	
INITIALS	DATE			
RETURN TO:	Caycee Buscag 12711 Walton I Midlothian, Vi	Ridge Lane		