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:

_____

INTIALS_____DATE_____

ANY ALLLERGIES TO FOOD, DRINK, MEDICINE OR DRUGS:

_____

INITIALS_____DATE_____

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