

ATHLETE'S MEDICAL INFORMATION AND AUTHORIAZTION

Athlete's Name: Birth Date:			
Parent/Guardian's Na	ame:		
Address:		_City:	Zip:
Home Phone:	Cell Phone:		E-mail :
Physician's Name:		Physician's	s Phone:
Insurance Co:		_ Policy #:	
*It would be helpful t	o pack a copy of your child'	s insurance o	card with them on the trip.
	THE FOLLOWING STATI WITH A SIGN		
thereof, including the above, to any hospital	Team Manager, chaperone, , and the hospital staff and i	, or coach, ha its medical st	vimming Inc., and any representative has my permission to take the athlete name staff have my permission to provide ing of the above named athlete.
Signature: (Athlete's	Parent/Guardian)		Date
	SH THE NAMES OF MEDIO DATE EACH ENTRY	CATION AN	ND ALLERGIES
ALL MEDICATION	THE ABOVE ATHLETE IS	S PRESENT	ΓLY TAKING:
INTIALS			
ANY ALLLERGIES	TO FOOD, DRINK, MEDIC	CINE OR DI	ORUGS:
INITIALS	DATE		
RETURN TO:	Maureen Tolliver 3 Monarch Court		

Stafford VA 22554