

5 ATHLETE'S MEDICAL INFORMATION AND AUTHORIAZTION

Athlete's Name:	Birth Date:	
Parent/Guardian's Name:		
Address:	_City:	Zip:
Home Phone: Cell Phone:		E-mail :
Physician's Name:	Physician's Ph	one:
Insurance Co:	_ Policy #:	
*It would be helpful to pack a copy of your child'	s insurance car	d with them on the trip.
THE FOLLOWING STATI WITH A SIGN	EMENT MUST NATURE AND 1	
In case of emergency, when I can not be reached, thereof, including the Team Manager, chaperone above, to any hospital, and the hospital staff and it treatment which a physician deems necessary for	, or coach, has n its medical staff	my permission to take the athlete named have my permission to provide
Signature: (Athlete's Parent/Guardian)		Date
YOU MUST FURNISH THE NAMES OF MEDI AND INTIAL AND DATE EACH ENTRY	CATION AND	ALLERGIES
ALL MEDICATION THE ABOVE ATHLETE I	S PRESENTLY	TAKING:
INTIALSDATE		
ANY ALLLERGIES TO FOOD, DRINK, MEDIC	CINE OR DRU	GS:
INITIALSDATE		
RETURN TO: Maureen Tolliver 3 Monarch Court		

Stafford VA 22554