



ATHLETE'S MEDICAL INFORMATION AND AUTHORIZATION

Athlete's Name: _____ **Birth Date:** _____

Parent/Guardian's Name: _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Parent Cell Phone:** _____ **Parent E-mail :** _____

Physician's Name: _____ **Physician's Phone: (_____)** _____

Insurance Co: _____ **Policy #:** _____

***It would be helpful to pack a copy of your child's insurance card in their swim bag for 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 it's 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 AND DATE EACH ENTRY

ALL MEDICATION THE ABOVE ATHLETE IS PRESENTLY TAKING:

INITIALS _____ **DATE** _____

Please List ANY ALLLERGIES- FOOD, DRINK, MEDICINE, DRUGS, FEATHERS ETC.

INITIALS _____ **DATE** _____