CVHAA Patriots ATHLETICS

Central Virginia Homeschool Athletic Association

www.cvhaa.org

MEDICAL PERMISSION

Player's Name: _____ DOB____/____/____ M/F_____

Parent's Name(s):_____

Address:_____

house/apt# Street City zip

Home Phone: _____ Cell ph.: _____

Email Address: _____

In the event of any injury or emergency, if I or my emergency contact cannot be notified, I authorize the individual(s) in charge to obtain medical treatment for my child as deemed necessary by competent medical personnel. Additionally, I understand that I am fully responsible for any and all charges incurred due to such treatment.

- Medications taken:

  _____

- Known allergies:

  _____

- Any other pertinent medical history:

  _____

- Doctor's name: _____
- Doctor's phone: _____
- Doctor's address: _____
- Insurance Information: Provider: _____

  Policy #: _____
- Emergency contact (other than parent):

  Name: _____ Phone: _____

PARENT'S SIGNATURE: _____ ***DATE:*** _____

Form must be submitted to coaching staff at first practice. Athlete will not be permitted to participate in any practices until form is received. This form is in effect for the 2018/2019 season. Revised 10/2018