Central Va Homeschool Athletic Association
Medical Permission
Volleyball

Player Name _____
Date of Birth _____
Parent/Guardian _____
Address _____
_____
Phone _____
Email _____
Emergency Contact _____
Phone _____

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: _____
Other pertinent medical history: _____
_____
Doctor's Name: _____
Doctor's Phone: _____
Insurance Information: Provider _____
Policy # _____
If you are "self pay" please initial here: _____

Parent/Guardian signature _____
Date: _____

This form must be submitted to the coaching staff at the first practice.