



Central Virginia Homeschool Athletic Association

www.cvhaa.net

MEDICAL PERMISSION

Player's Name: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Male/Female

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. Athletes will not be permitted to participate in any practices until form is received. This form is in effect for the 2010 spring Soccer season.