EMERGENCY CARE INFORMATION

(Coach: Keep a copy of this form for <u>each</u> team member <u>with you at</u> the tournament)

EVENT: 2020 Dulles VOICES Region 16 Tournament

LOCATION: Riverside High School, 19019 Upper Belmont Pl, Leesburg, VA 20176, USA

STUDENT'S NAME: _____ **Date of Birth**: _____

Address: _____**ZIP**

Father's Name: _____

Address : _____

Home Phone : _____ Work Phone: _____

Mother's Name: _____

Address (if different from above) :_____

Home Phone : _____ Work Phone: _____

Family Physician: _____ Phone: _____

Insurance Information (effective as of the tournament date):

Carrier: _____ Plan #_____ Policy # _____

Medical History

Allergies:

Insect stings _____

Food (please list) _____

Drugs (please list) _____

Medical conditions:

Please list any disabilities/conditions we should be aware of: _____

_____

Is your child currently under care of a physician for a medical problem? Yes _____ No _____

If yes, please explain_____

_____

List all medications and dosages your child receives on a continual basis or is receiving at the present

time : _____

Parental/Guardian Permission:

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter by an emergency room or nearest hospital. The medical staff has my authorization to provide treatment which a physician deems necessary for the well-being of my child. I agree to be responsible for all charges incurred.

Date : _____ Signature:_____ Relationship to student: _____