CONFIDENTIAL

Authorization for Medical Care of a Minor

I, _____ the undersigned parent or legal guardian of _____
do hereby authorized _____ **Athletic Association,** TO CONSENT to any x-ray examination, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist licensed under the laws of the State of Virginia.

IN GIVING THIS CONSENT I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hostel care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments of pr procedures, if an, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all medical treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health and safety of the above named minor.

Date _____ Parent/Legal Guardian Signature_____

Phone _____ Address _____

In case of an emergency please contact _____ Phone _____

Treatment Information

Minor's Birth Date _____ Minor's Allergies _____

Minor's Doctor _____ Phone _____

Minor's Medication _____

Date of Minor's Last Tetnus Shot _____ Hospital Preference _____

Does your child have any known allergies or is your child allergic to any medications? _____

If yes, please list any allergies and their reaction: _____

_____

_____

If there are any "Helpful Hints" (previous cheering, bathroom frequency, etc.) or "fears" (heights, being in front of people, etc.) you would feel helpful for me to know, please list them: _____

_____

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