

## EMERGENCY CARE INFORMATION

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

**EVENT:** 2019 Dulles VOICES Region 16 Tournament

**LOCATION:** Briar Woods High School, 22525 Belmont Ridge Rd, Ashburn, VA 20148

**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 on March 2, 2019):**

**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: \_\_\_\_\_