CHAA MEDICAL AUTHORIZATION FORM

Name of Player: ____

Date of Birth: ______________________

Known Allergies:____

Medical Conditions:____

Current Medications:____

Parent's Name: ____

Address: ____

City/State/Zip: ____

Phone #: _____________________ Cell # ______________________ Cell # ___________________

Email Address: ____

<u>Please attach copy of Health Insurance information to this form.</u>

Medical Authorization

In case of an emergency or accident during any Coastal Homeschool Athletic Association event or team activity involving my child, ________________________, which in the opinion of CHAA or team authorities present, requires immediate medical or surgical attention, I hereby grant permission to said CHAA or team authorities to obtain the services of a physician or to transport said child to hospital if it is deemed necessary. I hereby grant permission, also to said physician to treat said condition unless I am present and request otherwise or until I later request otherwise.

Date: ___________________

Signature of parent or guardian: ____