

MEDICAL INFORMATION AND AUTHORIZATION

NAME: _____ BIRTH DATE: _____

ADDRESS: _____ SCHOOL: _____

GRADE: _____

PHONE: _____ e-mail: _____

Emergency Phone Numbers: _____

Emergency Contact: _____

PARENT/GUARDIAN:

PARENT/GUARDIAN:

ADDRESS: _____

ADDRESS: _____

PHONE: _____

PHONE: _____

MEDICAL LIMITATIONS: _____

DOCTOR: _____ PHONE: _____

MEDICAL INSURANCE CO. _____

POLICY NUMBER: _____

I/we, the parent(s) or legal guardian of _____, hereby authorize the Mount Vernon Youth Basketball Club, it's coaches and representatives to seek immediate medical care for my/our child above named if deemed necessary and appropriate and in the event of my/our absence.

Dated: _____

PARENTS/LEGAL GUARDIANS:
