

Valencia County Homeschool Activities Association

Activity: _____

AUTHORIZATION FOR MEDICAL SERVICES

I/We request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event we cannot be reached, I/We parent(s)/guardian(s) hereby designate the Athletic Director, Team Coach, or his/her designee to act in my/our behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency because of illness or injuries sustained by my/our child/ward while participating in VCHAA athletics. In the event we cannot be reached, and the situation calls for medical attention, we recognize and relinquish our responsibility to a practicing physician and/or medical personnel acting in the best interest of my/our child/ward. I/We hereby assume financial responsibility for hospitalization, medical attention and surgery provided.

Family Physician _____ Phone _____

Address _____
Street City State Zip

Family Dentist _____ Phone _____

Address _____
Street City State Zip

Hospital Preference _____

Parent/Guardian Telephone: Work _____ Home _____ Emergency _____

Responsible Person (Emergency) _____ Phone _____

Date Student-Athlete's Name-**PRINT** Student-Athlete's Signature

Date Parent/Guardian's Name-**PRINT** Parent/Guardian's Signature

Date Team Coach-Signature

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Date Parent/Guardian's Name-**PRINT** Parent/Guardian's Signature

Date Team Coach-Signature