CONFIDENTIAL

Weaver Athletic Association

Authorization for Medical Care of a Minor

I,_____ the undersigned parent or legal guardian of._____do hereby authorize the Weaver 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 hospital 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 or 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.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Street Address Phone #

_____

City, State and Zip Code

In case of an emergency please contact

Emergency Contact Name _____

Phone # _____

Medical Treatment Information

Does your child have any known allergies or allergic reactions? Yes or No

Please list: _____

Medications: _____

Minor's Birthdate: ____/_____/_____ Hospital Preference: _____

Doctor: _____ Phone # _____

Date of Last Tetanus Shot: _____/_____/_____

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:

_____

_____