CLEVELAND VOLLEYBALL COMPANY
MEDICAL AUTHORIZATION FORM

ATHLETE NAME: ____
(*Please print*) Last First
Date of Birth: ____________________ **Home Phone:** ______________________________

Home Address: ___________________________ **City:** ________________ **Zip:** __________

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while participating in any CVC event, when parents or guardians cannot be reached. This information will be shared, as necessary, with Cleveland Volleyball Company staff or designee.

Residential Parent or Guardian

Mother's Name __________________________________ Cell Phone #: ________________
Father's Name __________________________________ Cell Phone #: ________________
Emergency Contacts:
1. ______________________________ Relation: _____________ Cell: _________________
2. ______________________________ Relation: _____________ Cell: _________________

It is extremely important that you provide **ANY** pertinent medical history or information about existing conditions that may affect your child while participating in any CVC event.
Medical Information: ____
____
Medications: ____
____
Allergies: ____

PART I OR II MUST BE COMPLETED
PART II: REFUSAL TO CONSENT
PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers/local hospital to be called:
Doctor____ Phone_____________________
Dentist____ Phone_____________________
Medical Specialist__________________________________ Phone_____________________
Local Hospital/Emergency Room Phone____
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian___________________________________ Date_____________

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment,
I wish the school authorities to take the following action:

Signature of Parent/Guardian___________________________________ Date___________