

SOUTHAMPTON HIGH SCHOOL

23350 Southampton Parkway, Courtland, VA 23837 * 757-653-2751 ph * 757- 653-0414 fax



MEDICAL AUTHORIZATION FORM

In order to complete in VHSL activities a student must have some type of medical insurance. Please complete this form so your child and the school will be prepared in the event that medical attention may be necessary.

DATE _____ STUDENT'S NAME _____ GRADE _____

STUDENT'S ADDRESS _____
Street Address City State Zip

INDIVIDUAL INSURANCE INFORMATION:

Medical Insurance Company	Policy Number/Member ID	Name of Policy Holder

Any additional information that might be needed: _____

In the event of an emergency in which my child may need medical treatment I can be reached at the phone number(s) / address below or you have my permission to contact the following persons if I cannot be reached.

In case you cannot contact me or the persons listed, I hereby authorize the school officials to provide whatever medical assistance may be necessary for my child to seek the services of the nearest available medical doctor.

I also, authorize the doctor, whom the school chooses, to provide whatever treatment may be necessary.

PARENT INFORMATION

MOTHER'S NAME	HOME PHONE	CELL PHONE	WORK PHONE
MOTHER'S PHYSICAL ADDRESS			
FATHER'S NAME	HOME PHONE	CELL PHONE	WORK PHONE
FATHER'S PHYSICAL ADDRESS			

AUTHORIZED PERSONS

CONTACT NAME	HOME PHONE	CELL PHONE	WORK PHONE
CONTACT NAME	HOME PHONE	CELL PHONE	WORK PHONE

It is also understood that the above names will be used to verify communication between parents and the school.

Parent/Guardian Signature: _____ Date: _____