

SASVBC TRAVEL AUTHORIZATION

*To be completed and signed by the athlete and his/her parent/guardian and returned to the chaperone PRIOR to travel. If not completed and signed, athlete is not permitted to travel.

ATHLETE NAME: _____ TEAM: _____

TOURNAMENT: _____ DESTINATION: _____

DEPARTURE DATE: _____ RETURN DATE: _____

I, _____ the parent/guardian of the above named athlete hereby agree to:

- Give permission to above named athlete to participate in the described above activity.
- Give permission for above named athlete to travel by private or commercial vehicle.
- Release Spike and Serve Club, its' agents, coaches and representatives from any and all liability to us and the athlete for any injury, damage, loss that may occur because of the athlete's participation in the event.
- In the event of illness or injury to the athlete, consent to authorize medical treatment as may be deemed necessary at no cost to SASVBC.

In case of emergency and a parent cannot be reached, I authorize any SASVBC representative (coach, and/or chaperone) to obtain medical treatment for my child (including but not limited to emergency room treatment) that may be deemed necessary for my child's welfare.

It is expected that athletes conduct themselves according to the SASVBC Athlete Travel Agreement.

I understand that for any major incident I will be notified by phone and my child will be sent home immediately at my expense including the transportation expense required for a chaperone to escort my child to the airport. All expenses incurred for this trip will be non-refundable.

I have read and understood both the SASVBC Travel Agreement and the above SASVBC Travel Authorization.

Parent Signature: _____ Date: _____

Athlete Signature: _____ Date: _____

SASVBC TRAVEL AUTHORIZATION/INFORMATION

ATHLETE: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE NUMBER: _____

I GIVE MY AUTHORIZATION TO DISPENSE THE FOLLOWING OVER THE COUNTER MEDICATIONS TO MY CHILD.

PLEASE CHECK ALL THAT APPLY:

- IBUPROFEN (Advil)
- ACETAMINOPHEN (Tylenol)
- Pepto Bismol
- Immodium AD
- Kaopectate
- Dramamine
- Mylanta
- Aspirin
- Other: _____

Medical/Physical Limitations: _____

Allergies: _____

Blood Type: _____

Notification of Possession of Prescription Medication(s):

My child will have the following medication(s) in his/her possession for his/her use only. I will ensure that all medications are sent with my child's name, physician name, dosage instructions and my own instructions:

Parent/Guardian Signature: _____ Date: _____