

2026 - 2027 HEALTH / EMERGENCY FORM

DO NOT LEAVE ANY SPACES BLANK or form unsigned. This form must be FULLY completed and signed by a parent/guardian AND physician to be enrolled at Saint Mary's College High School. All information is REQUIRED.

1. _____
Student's Last Name First Name Initial
2. _____
Address/City/State/Zip
3. Student's Date of Birth _____ Student's Cell Phone _____ Student's Home Phone _____
4. Parent Name: _____ Parent Name: _____
Relationship to Student _____ Relationship to Student _____
Work Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone: _____
5. Person who can be contacted in case of emergency (other than parent or guardian):

Name Phone

6. _____
Student's Physician City Phone

8. _____
MEDICAL INSURANCE CARRIER MEDICAL INSURANCE I.D. NUMBER

Primary subscriber name: _____

I give my consent for my child to participate in interscholastic high school sports at SMCHS: YES ____ NO ____
I give my consent for my child to participate in intramurals at SMCHS: YES ____ NO ____

In an emergency, if we cannot be reached, and our family physician is not available, I (we) hereby give Saint Mary's College High School permission to have the above student treated by a physician or the Saint Mary's College High School Athletic Trainer and to use the closest available medical facility. I hereby state that the information provided on this form is true and correct.

PARENT NAME (print)

PARENT SIGNATURE

Date

***** Bottom Portion to be Completed by Student's Physician*****

Male/Female ____ Age ____ Height ____ Weight ____ Blood Pressure ____ Glasses or Contacts? ____

Chronic illnesses such as asthma, diabetes, epilepsy, heart disease, etc.:

Allergies such as food, drugs, bites and stings, pollens, etc. (please indicate if Epi-Pen is needed):

Medications student is taking and for what reason (please include asthma inhalers):

I hereby certify that I have examined the above-named patient and have found him/her physically fit to participate in:

Interscholastic high school sports: YES ____ NO ____
Intramurals: YES ____ NO ____

Physician's Name (print)

Physician's Signature

Date

Address, City, State

Phone