ATHLETICS - MEDICAL and EMERGENCY FORM

AUTHORIZATION FOR CONSENT OF TREATMENT OF MINOR

In the event of a serious emergency and none of the persons listed below can be contacted, I authorize school officials to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, and rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at a certified hospital. I hereby agree to bear all costs incurred as a result of the foregoing:

MY CHILD IS ALLERGIC TO:

1. _____ 2. _____

_____ _____

Signature of Parent or Guardian *Date*

MEDICAL INSURANCE COVERING THE STUDENT:

Name of Policy

Company: _____ Number: _____

Are there any health conditions of your child that we should be aware of? Please list:

_____

_____

PAROCHIAL ATHLETIC LEAGUE PARTICIPANT EMERGENCY INFORMATION

School: Grade:	Sport:
Student:	Home Phone:
Father:	Mother:
Father Work Ph:	Mother Work Ph:
Father Cell Ph:	Mother Cell Ph:
Father Email:	Mother Email:
In case of emergency (when parents cannot be reached), please contact:	
Name/Relationship	Phone:
Physician Name:	Phone:
Hospital:	
Dentist Name:	Phone: