SAINT JOSEPH SCHOOL
STUDENT ATHLETE EMERGENCY INFORMATION AND MEDICAL CARE FORM

Student Athlete Name: _____ Birth Date _____
Address:_____Home Phone:_____
Grade: _____ Sports:_____

PURPOSE — To enable parents/guardians to authorize the provision of emergency treatment for children whom become ill or injured while under school authority, when parent/guardians cannot be reached.

Emergency Contact Information Full Name(s) of Residential Parent(s) or Guardian(s):
Parent or Guardian #1: _____
Parent or Guardian #1: Work Phone: _____ Cell Phone: _____
Email: _____
Parent or Guardian #2: _____
Parent or Guardian #2: Work Phone: _____Cell Phone_____
Email: _____
Emergency Contact Other Than Parent/Guardians Above:
Name: _____ Relationship: _____
Address:_____ Phone:_____

Medical Facts Requiring Special Attention (drug or food allergies, medications, asthma, diabetes, etc.)
_____
_____
Date of last Tetanus shot: _____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

In the event of an emergency and that the emergency contacts cannot be contacted, I give my permission to Saint Joseph School and its representatives to transport and seek medical evaluation/attention for Student listed above.
Insurance Carrier: _____
Policy Number: _____ Group Number: _____
Hospital Preference: _____
Family Physician: _____ Phone: _____
Family Dentist: _____ Phone: _____
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 for the school authorities to take the following action:
_____
_____
Signature of Parent/Guardian: _____ Date: _____