*** PLEASE USE BLACK OR BLUE INK ONLY ***

St. Joseph Hessen Cassel

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 _____
E-mail: _____
Parent or Guardian #2: _____
Parent or Guardian #2: Work Phone _____ Cell Phone _____
E-mail: _____
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 Charles School and its representatives to transport and seek medical evaluation/attention for Student listed above.
Insurance Carrier: _____
Policy Number: _____ Group Number: _____
Hospital Preference: _____
Family Physican: _____ Phone: _____
Family Dentist: _____ Phone: _____
Signature of Parent/Guardian_____ Date: _____

PART II – REFUSAL TO CONSENT (Do not complete this portion if PART I was completed.)

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: _____