St. Mary Catholic School
Athletic Department

Athlete's Name__________________________ Age______ Grade_________ Year_________

Parents/Guardian Names____

Address_______________________________ City_______________ Zip_________________

Home Phone_____________________ Work Phone___________________ for_______________(name)

Cell phone______________________ for ________________ (name)

Doctor name______________________________________ Phone____________________________

Blood Type (if known)________________________________

Please list any medications____

Please list any allergies____

Please list any physical problems____

Does your child have insurance coverage? _______ Yes _______ No

Insurance Company____________________________ Is this an HMO________ or PPO_________?

Policy in the name of____________________________ Policy Number____________________________

Hospital Choice:____Valley West _____Rush-Copley_____Delnor_________Other(Please provide name)

Consent to Emergency Medical Treatment

In the event the above named student athlete required emergency medical treatment and neither parent nor guardian is present to consent, I do hereby consent to such emergency medical treatment as may be required.

Acknowledgement of Consent:

Parent Signature:____________________________________ Relationship:___________ Date:_______

Parent Signature:____________________________________ Relationship:___________ Date:_______