

Diocesan Inter-Scholastic Sports Program Medical Consent
Emergency Information For Use By Coaches

Grade: _____ Homeroom _____

Student Name: _____
Last First Middle

Address: _____ City _____ Zip _____

Mother's Name/Guardian: _____

Phone: (H) _____ (C) _____ (Email) _____

Father's Name/Guardian: _____

Phone: (H) _____ (C) _____ (Email) _____

In case of an Emergency in which the parents cannot be reached, please call:

	Name	Relationship	Phone Number(s)
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

Has the child any drug/food/environmental/insect, etc. allergies: _____

Additional information or concerns that a coach needs to know regarding participation of your child in sports. (Such as cystic fibrosis, diabetes, heart conditions, etc.)

Would your child require medication during sports practice? If yes, for what condition and the name of the medication? _____

Does your child have any special requirements in order to participate in sports? (i.e. dental appliances, braces, contact lens, splints, etc.) _____

Family Physician _____ City _____ Phone _____

Hospital of Choice _____ Insurance Co. _____

Date of last Tetanus shot: _____

If any emergency arises, the school will try to contact the student's parent/guardian. If neither parent or guardian can be reached, I give permission to Dr. _____ to be wholly responsible for the care of my child. If the physician is unavailable in the event of a major emergency, the administration is directed to seek emergency care at the medical or hospital facility indicated above. I will be responsible for the payment of all expenses incurred.

Signature of Parent or Guardian Date