

ATHLETICS

Parochial Athletic League

SPORT: _____ **GRADE:** _____ **TEACHER** _____

STUDENT _____ **HOME PHONE** _____

Father _____

Mother _____

Father Business Phone _____ **Mother** _____

Father Cell Phone _____ **Mother Cell Phone** _____

Father E-Mail _____ **Mother E-Mail** _____

In case of emergency (when parents cannot be reached), please contact;

_____	_____	_____	_____	_____	_____
Name	Relationship	Phone	Name	Relationship	Phone

_____	_____	_____
Physician	Name	Phone
		Hospital _____

_____	_____
Dentist	Phone
	Name

AUTHORIZATION FOR CONSENT OF TREATMENT OF MINOR

In the event of serious emergency, and none of the persons listed above 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:

Signature of Parent

Date

I do not choose to sign the above statement. In the event of an accident or emergency, please _____

Signature of Parent

MEDICAL INSURANCE COVERING STUDENT _____
Name of Company Policy No.

Are there any health conditions of your child that we should be aware of? _____
