

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

**SAINT CHARLES BORROMEO 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 _____

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 Physician: _____ 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: _____