ATHLETICS **Parochial Athletic League**

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

STUDENT_____ **HOME PHONE**_____

Father_____

Mother_____

Father Business Phone_____ Mother Business Phone_____

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_____ Hospital _____
Name Phone

Dentist_____
Name Phone

AUTHORIZATION FOR CONSENT OF TREATMENT OF MINOR

In the event of serious emergency, and none of the persons listed on the reverse 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 THE STUDENT: _____
Name of Company Policy No.

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

_____