Diocesan Inter-Scholastic Sports Program Medical Consent

Emergency information for use by coaches

Grade: _____ /Home room

Student Name: _____
Last First Middle

Address: _____ City _____ Zip _____

Mother's Name/Guardian: _____

Phone: (H) _____ (W) _____ (C) _____

Father's Name/Guardian: _____

Phone: (H) _____ (W) _____ (C) _____

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 asthma, 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.

_____ Date: _____

Signature of Parent or Guardian

2/05