

**ST. JOSEPH HIGH SCHOOL SPORTS MEDICINE EMERGENCY FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Parents/Guardians**

Name: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

**RELATIVE OR FRIEND TO BE NOTIFIED IF PARENTS CANNOT BE REACHED :**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Type: HMO PPO Traditional Other \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Primary Cardholder: \_\_\_\_\_

**PLEASE CHECK ANY OF THE MEDICAL CONDITIONS BELOW THAT APPLY TO YOUR CHILD:**

\_\_\_\_\_ Heart condition \_\_\_\_\_ Diabetes \_\_\_\_\_ Penicillin Allergy \_\_\_\_\_ Insect Allergy \_\_\_\_\_ Epilepsy \_\_\_\_\_ Asthma

Please list any Prescription Medications your son or daughter are currently taking:

\_\_\_\_\_

Please list any other allergies or medical concerns your child may have if not listed above:

\_\_\_\_\_

*We give permission for our son/daughter to participate in the sport of \_\_\_\_\_.*  
*In cast of an emergency, and if immediate observation or treatment is urgent in the judgment of the coaches and St. Joseph Sports Medicine Team, we hereby give our consent to allow the coaches and St. Joseph Sports Medicine Team to administer appropriate first aid, emergency care, securing of medical aid and ambulance service if necessary and sending our child to the hospital. We grant permission to the hospital to initiate Emergency Medical Treatment. (This form will not be used before attempting to contact the athlete's legal parents/guardians.)*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

----- Please complete bottom section along with the top -----

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