

**Diocesan Inter-Scholastic Sports Program Medical Consent**  
Emergency information for use by coaches

Grade: \_\_\_\_\_ /Home room \_\_\_\_\_

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Last City First Middle 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.

\_\_\_\_\_  
Signature of Parent or Guardian

Date: \_\_\_\_\_