

Parochial Athletic League

ATHLETICS MEDICAL RELEASE

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

STUDENT: **HOME PHONE:**

FATHER: **MOTHER:**

Business Phone: Business Phone:

Cell Phone: Cell Phone:

E-Mail: E-Mail:

EMERGENCY CONTACT INFO (in case of emergency, and when parents cannot be reached, please contact:)

Contact #1 Name: Relationship: Phone: **Contact #2 Name:** Relationship: Phone:

Physician: **Hospital:**

Name: Phone:

Dentist: **MEDICAL INSURANCE COVERING THE STUDENT:**

Name: Phone: Name of Company: Policy Number:

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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 an 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 Physicians 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:

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

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: Date: