

Please PRINT Clearly.

ST. JOHN ACADEMY ATHLETICS PERMISSION FOR EMERGENCY CARE

To be completed by parent/guardian at beginning of the Sport in Season

NAME OF ATHLETE: _____ GRADE: _____

Home Address: _____
(Street) (City) (Zip)

Athlete's Date of Birth: _____ Circle One: Male Female

Father's Name: _____ Home Phone: _____ Work Phone: _____

Father's Email Address: _____ Cell Phone: _____

Father's Address (if different than home): _____

Father's Workplace and Address: _____

Mother's Name: _____ Home Phone: _____ Work Phone: _____

Mother's Email Address: _____ Cell Phone: _____

Mother's Address (if different than home): _____

Mother's Workplace and Address: _____

Name(s) of Person(s) or Agency Having Legal Custody: _____

Medical Information

Child's Doctor _____ Phone Number: _____

Outstanding Medical History (e.g. diabetes, heart disease, contact lenses, hearing aids, etc.)

Does your child have Sports Induced Asthma: (Circle One) Yes NO

Do they need/use an Asthma Inhaler: (Circle One) Yes NO

If circled Yes, Does Saint John Academy have the proper Asthma paperwork on File: Yes No

Child's Allergies (if any) _____ Action to Take: _____

Medications Child is Taking: _____ Date of Last Tetanus Shot: _____

Insurance Company: _____ Policy Number: _____

Emergency Contacts: In the event a parent cannot be reached, **you must** give the name, address, and phone number of two persons who could pick up and take your child home in a timely manner.

(1) _____
(Name) (Address) (Relationship) (Phone)

(2) _____
(Name) (Address) (Relationship) (Phone)

Lastly, **if I cannot be contacted in an emergency**, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment, which a physician deems necessary for the well-being of my child.

* _____
(Signature of Parent/Guardian) (Date)