ST. JOHNS MIDDLE SCHOOL ATHLETICS

Emergency Care Permission

Student Name_____ Address_____Birth Date_____

Parent(s) Name _____Phone Number(s)_____

Insurance Company_____Policy Number_____

In case of illness or injury, you should contact one of the following **(Must have two numbers)**

1._____Ph. #_____

2._____Ph. #_____

If it is impossible to contact one of the above persons, you may contact our family doctor:

Doctor: _____Ph. _____

List any allergies, medications or special care needs:

_____
_____
_____

List any serious illness or injuries your son or daughter has had or any other physical problems you are aware of:

_____
_____
_____

In case of serious illness or injury, I hereby request that all authorized school personnel transfer my child directly to the hospital, or send by ambulance as needed. I understand I will assume all financial obligations.

Hospital Preferred: _____

_____

Parent/Guardian Signature Date

PLEASE RETURN COMPLETED FORM TO THE ATHLETIC OFFICE