Student Name: _____ Grade:_____

St. Albans Country Day School

SPORTS/ACTIVITIES MEDICAL INFORMATION AND EMERGENCY CARE FORM 2026-2027

AUTHORIZATION FOR CONSENT OF TREATMENT OF MINOR

In the event of a serious injury or other emergency and none of the persons listed below can be contacted, I authorize a representative of St. Albans Country Day School to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent to any 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 physician's office or at a certified hospital. I hereby agree to bear the cost incurred as a result of the foregoing. **Parent/Guardian Initials _____**

For an Alternative Family Treatment Option, check here _____

I do not choose to initial the above statement. In the event of an accident or emergency, please:

MY CHILD IS ALLERGIC TO:

1._____ 2._____

_____ _____

Signature of Parent or Guardian Date

MEDICAL INSURANCE COVERING THE STUDENT:

Name of Company:_____ Policy Number_____

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

_____ _____

Signature of Parent or Guardian *Date*

PAROCHIAL ATHLETIC LEAGUE EMERGENCY CARD

Student:_____Grade:_____

Father:_____ Mother:_____

Father Cell Phone:_____ Mother Cell Phone:_____

Father Work Phone:_____ Mother Work Phone:_____

Father Email:_____ Mother Email:_____

IN CASE OF EMERGENCY (WHEN PARENTS CANNOT BE REACHED), PLEASE CONTACT:

Name/Relationship_____ Phone:_____

Name/Relationship_____ Phone:_____

Physician Name:_____ Phone:_____

Hospital:_____

Dentist Name:_____ Phone:_____