

Students Name: _____ PLAYER NUMBER (office use only) _____

St. Albans Country Day School
SPORTS/ACTIVITIES MEDICAL INFORMATION AND EMERGENCY CARE FORM
2022-2023

AUTHORIZATION FOR CONSENT OF TREATMENT OF MINOR

In the event of an accident, injury or other emergency, when a parent is not available, I hereby authorize a representative of St. Albans Country Day School to make such arrangements necessary for my child to receive medical or hospital care and transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child as considered necessary. In the event said named physician is not available, I authorize such care and treatment to be rendered by any licensed physician or surgeon. I also understand that I shall be liable for all costs incurred as a result of such care and treatment.

MY CHILD IS ALLERGIC TO:

1. _____ 2. _____
3. _____ 4. _____

Signature of Parent or Guardian

Date

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

Signature of Parent or Guardian

Date

MEDICAL INSURANCE COVERING THE STUDENT:

Name of Company: _____ Policy Number _____

Parent/Guardian Initials for Specific Season: Fall _____ Winter _____ Spring _____

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

PAROCHIAL ATHLETIC LEAGUE EMERGENCY CARD

Sport: _____	Grade: _____	Teacher: _____
Student: _____		Home Phone: _____
Father: _____		Mother: _____
Father Work Ph: _____		Mother Work Ph: _____
Father Cell Ph: _____		Mother Cell Ph: _____
Father Email: _____		Mother Email: _____
In case of emergency (when parents cannot be reached), please contact:		
Name/Relationship _____		Phone: _____
Name/Relationship _____		Phone: _____
Physician: _____		Phone: _____
Hospital: _____		
Dentist: _____		Phone: _____