

**St. Catherine of Siena School/Parish Medical Form
(for participation in sports)**

Child's Last Name

First Name

Birth Date

Street Address

Current Grade

City

Zip

Telephone no.

Cell Phone no.

Mother/Legal Guardian

Work Phone no.

Father/Legal Guardian

Work Phone no.

E-Mail Address

In the event of an apparent serious illness or accident when I/we cannot be reached, I wish one of the following persons to be notified by telephone. They are authorized to act in my/our absence regarding decisions to provide medical care to my child as identified above.

1. Name _____ Relationship _____
Address _____ Phone _____

2. Name _____ Relationship _____
Address _____ Phone _____

In the case of emergency when I or my emergency contacts cannot be reached, I give permission to obtain or administer whatever medical services should be necessary.

I also agree to inform the coach in writing should my child be on medication during any game or practice.

Parent/Legal Guardian _____

Physician Name _____ Telephone _____

Dentist Name _____ Telephone _____

Hospital or Emergency Room Preferred _____