ST. PAUL CATHOLIC HIGH SCHOOL
ATHLETIC PERMISSION FORM

Sport to be played
boys/girls_____Season/Year_____

To be completed by the *PARENT/GUARDIAN AND STUDENT* and returned to the **head coach** prior to the first day of practice.
To be kept on file by the coach.

STUDENT'S NAME_____GRADE_____HOMEROOM_____

ADDRESS_____
Street-City- State-Zip Code

AGE_____DATE OF BIRTH_____PHONE_____

Date_____ Signature of Student_____

PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above student to engage in interscholastic athletics at St. Paul Catholic during the current school year and to accompany the team as a member on its out-of–town trips. *I understand that my son/daughter will be expected to adhere firmly to all established athletic policies.*

Date_____ Signature of Parent/Guardian_____

EMERGENCY INFORMATION

(To be completed by parent/guardian)

PRIMARY EMERGENCY CONTACT:
PARENT/GUARDIAN_____
HOME PHONE_____
CELL PHONE_____

SECONDARY EMERGENCY CONTACT:
PARENT/GUARDIAN_____
HOME PHONE_____
CELL PHONE_____

THIRD EMERGENCY CONTACT: In the event parents cannot be contacted, please contact:

Name_____Relation_____

HOME PHONE_____
CELL PHONE_____

Health Insurance Provider_____Policy#_____

MEDICAL TREATMENT CONSENT

I,_____ The parent/guardian of the above named student, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance. I understand this authorization will be enforced when I cannot be contacted and provide for immediate treatment.

Please make the following notations on my son/daughter's records:

Is you child taking any Medication? Yes ____No____, Name of Medication_____
Medication Allergies and Symptoms_____
Other relevant medical information (e.g. contact lens wearer, history of family diabetes, epilepsy, heart murmurs)
_____

Date_____ Signature of Parent/Guardian_____

Revised 7/28/20115