

**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* for each season 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: \_\_\_\_\_ SECONDARY EMERGENCY CONTACT: \_\_\_\_\_  
PARENT/GUARDIAN \_\_\_\_\_ PARENT/GUARDIAN \_\_\_\_\_

HOME \_\_\_\_\_ CELL \_\_\_\_\_  
PHONE \_\_\_\_\_ PHONE \_\_\_\_\_

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

Name \_\_\_\_\_ Relation \_\_\_\_\_

HOME \_\_\_\_\_ CELL \_\_\_\_\_  
PHONE \_\_\_\_\_ 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 your 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 \_\_\_\_\_