Student Name: _____ Grade:_____

St. Albans Country Day School

SPORTS/ACTIVITIES MEDICAL INFORMATION AND EMERGENCY CARE FORM 2024-2025

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.

Parent/Guardian Initials for Specific Season: Fall_____ Winter_____ Spring_____

MY CHILD IS ALLERGIC TO:

1._____ 2._____

3._____ 4._____

_____ _____

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:

_____

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

_____

_____

_____ _____

Signature of Parent or Guardian Date

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: