

**St. Anne-Pacelli Sports Medicine**

**Athletic Emergency Information**

**Please Print Except for Signatures**

Name \_\_\_\_\_ Year: 5<sup>th</sup> / 6<sup>th</sup> / 7<sup>th</sup> / 8<sup>th</sup> / Fr / So / Jr / Sr Birthdate \_\_\_\_\_

Parent/Guardian: Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Athlete's Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Private (Primary) Insurance**

Co. Name: \_\_\_\_\_ Pre-Authorization Phone # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Other #: \_\_\_\_\_

My Son / Daughter is covered by the above insurance Policy. Yes: \_\_\_\_\_ No: \_\_\_\_\_

Known Allergies (drug, food, insects, etc...): \_\_\_\_\_

Special Medical Problems: \_\_\_\_\_

Medications (Inhaler, Insulin, etc...) \_\_\_\_\_

**Parent / Guardian Consent to Treatment of Student Athlete**

I, \_\_\_\_\_, the undersigned parent / guardian of Student: \_\_\_\_\_

SSN: \_\_\_\_\_

I do hereby authorize the St. Anne-Pacelli athletic trainer or school representative on my behalf to consent to any medical treatment deemed necessary by any licensed physician / surgeon in the event of illness or injury to the above named minor.

This consent to treat is intended to cover any illness or injury sustained while participating in any school athletic competition or practice, on or off campus, and while traveling to and from the event.

If, in the judgement of any representative of the school, the above named student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, trainer, nurse, hospital or school representative: and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I hereby authorize any hospital, which has provided treatment to the above named student to surrender custody of that student to the athletic trainer or school representative upon completion of treatment.

These authorizations shall remain effective until the end of the 20\_\_ / 20\_\_ school year.

\_\_\_\_\_

\_\_\_\_\_

**Parent / Guardian**

**Date**