The de Paul School

2018-2019 Athletics Emergency Treatment Authorization form

Student Information **Team:** _____

Name: ________________________________ __________________ ______
(*Last*) (*First*) (*MI*)

Address: ____

Phone: ______________________________ Date of Birth:_________________

Parent/Guardian Information

Name: ____

Address: ____

Phone: ________________________ Secondary Phone:_______________

Email Address:____

Family Physician or Pediatrician

Name: ____

Practice: ____

Phone: ________________________ Preferred Hospital: ____________________

Insurance Information

Do you have insurance? ☐ Yes ☐ No

Company Name: ____

Policy Number: ____

Policy Holder Name: ____

Notice to all parents/guardians: Prior to participation in any physical activity, players should be seen by their family physician. The de Paul School requires your permission to treat your student in cases of emergency during practice or competitions.

The de Paul School has my permission to treat the child listed in case of emergency.

Parent/Guardian Signature: ____

Date: ________________________