

ST. PAUL'S SCHOOL - EMERGENCY/STUDENT INFORMATION FOR ATHLETES

STUDENT NAME: _____

PARENT/GUARDIAN: _____

STREET ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE #: _____ STUDENT CELL: _____

MOM EMAIL ADDRESS: _____

DAD EMAIL ADDRESS: _____

STUDENT SS# (last 4 digits): _____ BIRTHDATE: _____

(student)

DAD CELL PHONE #: _____ DAD WORK #: _____

MOM CELL PHONE #: _____ MOM WORK #: _____

EMERGENCY NAME: _____

(other than parent)

EMERGENCY PHONE #: _____

INSURANCE CO. NAME: _____

INSURANCE GROUP #: _____

INSURANCE MEMBER ID #: _____

INSURANCE PHONE #: _____

ALLERGIES (IF ANY): _____

MEDICAL CONDITION(S): _____

INJURIES OR RESTRICTIONS: _____

MEDICINE TAKING CURRENTLY: _____

*** I hereby consent for a qualified physician or surgeon to examine and prescribe or perform treatment, including surgery that is deemed advisable for the welfare of the above named student-athlete.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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Date: _____