HOLY ANGELS CATHOLIC ELEMENTARY SCHOOL
230 North 8th Avenue • West Bend, WI 53095
(262) 338-1148 www.has.pvt.k12.wi.us

Medical Information and Emergency Consent Form

To be carried by coach during activity

Student/Athlete: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Grade: _____

Parent/Legal Guardian: _____

Address: _____ Home Phone:_____

Employer: _____ Work Phone: _____

Parent/Legal Guardian: _____

Address: _____ Home Phone:_____

Employer: _____ Work Phone: _____

Family Physician: _____ Phone: _____

Group/Address: _____

Hospital of Preference: _____

Insurance Provider: _____

Group #: _____ Policy #: _____

Medical Problems: _____

Allergies: _____

In the event of an injury or illness, I grant permission to any and all health care providers designated by a representative of Holy Angels School (coach, volunteer, staff or principal) to provide my child with any and all necessary medical care related to the injury or illness. I further understand that I will be contacted as soon as practical as to the medical emergency and be provided with all the necessary information related to the medical emergency. I further agree to accept primary financial responsibility for all medical care provided.

Signature of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____