



SANTA MARGARITA CATHOLIC HIGH SCHOOL EMERGENCY HEALTH FORM

Student's Name _____ Date ____/____/____

Address _____ City _____ Zip _____

Phone (____) _____ 09-10 Grade _____ Sex _____ Birth Date ____/____/____

Father's Name _____ Mother's Name _____

Father's Cell Phone (____) _____ Mother's Cell Phone (____) _____

Father's Work Phone (____) _____ Mother's Work Phone (____) _____

Student's Last Tetanus/Toxoid Booster _____

Allergies to any Drugs or Foods _____

Any Special Medications or Medical Conditions _____

(Circle One) I understand the Athletic Training staff does not carry or dispense pain relievers. Yes No

May the above student be given Tylenol or Ibuprofen by the Team Physician or School Nurse? Yes No

May the above student be given a health examination by the school physician? Yes No

May the school officials call a Physician to attend to the above student in case of an emergency if the Parent or Guardian cannot be immediately contacted? Yes No

Name of Physician preferred _____ Phone (____) _____

Insurance Company _____ Policy Number _____

IN CASE OF EMERGENCY AND PARENTS CANNOT BE REACHED, THE SCHOOL MAY CALL:

Name _____ Relation _____ Phone (____) _____

Name _____ Relation _____ Phone (____) _____

Authorization to Treat Minor

I (We) the undersigned Parent(s) or Legal Guardian of _____, a Minor, do hereby authorize and consent to Any X-Ray, Examination, Anesthetic, Medical or Surgical Diagnosis rendered under the general or special supervision of any member of the Medical Staff. This also includes Emergency Room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act. This does not exclude the staff of any Acute General Hospital holding a current license to operate a Hospital from the State of California Department of Public Health. It is understood that this Authorization is given in advance of any specific diagnosis, treatment, or Hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that every effort shall be made to contact the Undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

This Authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

We (parent/guardian and student) have read and understood the Civil Code and are aware of the responsibilities and obligations our son/daughter have taken. We approve and will support this code. We also understand that sports (especially contact sports) are potentially dangerous, and could lead to serious injury, paralysis or death. We understand that a medical doctor will not be in attendance at practices or games. Knowing these facts, we give our consent for our son/daughter to participate in athletics or activities and to travel with a representative of the school on team trips.

Parent/guardian signature _____ Date ____/____/____

Student signature _____ Date ____/____/____

SPORT: FB TN VB G XC RH WP BB SOC WR SW SB BSB TF LAX CH