St. Augustine's

CYO BASKETBALL

EMERGENCY NOTIFICATION & MEDICAL RELEASE

Player: _____ **DOB**: _____

In the event of an accident or injury resulting in a medical emergency, please notify

PRIMARY CONTACT

Name: _____ **Relation**: _____

Home Ph#: _____ **Cell Ph#**: _____

SECONDARY CONTACT (if the above is unavailable)

Name: _____ **Relation**: _____

Home Ph#: _____ **Cell Ph#**: _____

PARENT or GUARDIAN AUTHORIZATION

In case of emergency, I hereby authorize my child to be treated by certified emergency personnel (i.e. EMT, First Responder, E.R. Physician).

Family Physician: _____

Phone: _____

Hospital Preference: _____

Please list any allergies/medical problems, including those requiring maintenance medications (i.e. Diabetic, Asthma, Seizure Disorder):

_____

_____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem that may interfere with or alter treatment.

_____

AUTHORIZED PARENT/GUARDIAN SIGNATURE DATE