St. Catharine Athletic Association
Emergency Information Form

Child's Last Name _____ Child's First Name _____ Date of Birth _____

Address _____ Apt# _____ Phone # _____

Father or Guardian _____ Place of Employment _____ Business Phone _____

Mother or Guardian _____ Place of Employment _____ Business Phone _____

If parents cannot be reached, please call: (Please list someone who can be reached during practice or game hours to pick up and care for you child.)

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Doctor's Name _____ Phone _____ Dentist's Name _____ Phone _____

In an emergency, when parents cannot be reached, may the coach or designee send your child to the hospital?

Yes _____ No _____ Hospital of Choice _____

Does your child have any of the following conditions? Diabetes_____ Asthma_____
Epilepsy____ Heart Condition_____ Bleeding_____ Contact Lenses_____
Dental Appliance_____ Medical or Surgical Appliance_____
Allergies (please specify) _____
Vision Problem_____ Hearing Problem_____ Other_____ On Daily Medication_____ If yes,
Please specify_____

Has your child been hospitalized?_____ Reason_____

Any unusual condition or comments: _____

My child has my permission to: walk home___ Picked up by someone other than parent_____
ride bike ____ other (specify)_____

I understand this permission and information is valid for the current sports season only.
I will notify the coach or athletic coordinator of any changes in this information.

Mother's signature _____ Date_____

Father's signature _____ Date_____