

**Archdiocese of Milwaukee  
Medical Information & Emergency Consent Form**

Participant's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Other Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

**Medical Information:**

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Hospital of preference \_\_\_\_\_

Insurance Info: Subscriber \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ Company \_\_\_\_\_

Pre-existing Medical Condition – e.g. allergy, asthma, chronic illness, etc.  
\_\_\_\_\_

I authorize the coaching staff to provide emergency medical treatment of an injury or illness to my child if qualified medical personnel consider treatment necessary. I further authorize any qualified licensed physician to render medical treatment which in his or her judgment may be deemed necessary in the care of \_\_\_\_\_ (child's name).

\_\_\_\_\_  
Parent/Legal Guardian Date \_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian Date \_\_\_\_\_

