HOLY ANGELS CATHOLIC ELEMENTARY SCHOOL
230 N. 8th Avenue, West Bend, WI 53095
(262)338-1148 haswb.org

Our Mission: To proclaim the Gospel, serve others, and praise God as we grow in faith, knowledge, values and respect.

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: _____

I authorize the coaching staff to provide emergency medical treatment of any injury to or illness by my child. 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: _____ Email:_____