St. Norbert School
Coaches Emergency Medical Information Card

Student's Name Grade Date of Birth
Parents' Name Phone
Address
Child resides with mother father both guardian (name _____)

In case of emergency please contact *(number in order of preference - local numbers preferred)*

Father's name/place of employment	**Mother's name/ place of employment**
Name	Name
Address	Address
Phone	Phone
Friend or relative	
1. Name	Phone
2. Name	Phone
3. Name	Phone
Student's physician	Phone

If emergency treatment is required, may school authorities use their own judgment to secure the services of the doctor most accessible if none of the people listed above can be reached?

YES NO Date: _____ **Signature _____**
(parent or guardian)

Authorization for Emergency Treatment of Minor

The undersigned is the parent/legal guardian of the minor identified.
2. This authorization is being provided to the Emergency Services Department for use in the event of the need for emergency treatment of the minor identified when neither the undersigned, the family physician nor the relative or friend identified can be reached to provide consent to treatment.
Minor's Name:
Health/Hospitalization Insurance:
Insurer:
Policy Number:

Consent

The undersigned hereby authorizes Physicians of the Emergency Services department or their designee (who must be a fully licensed Physician) to perform on the minor identified below, such emergency treatment or procedures as deemed appropriate, provided, however, that my consent or the consent of the family physician, friend, or relative identified will first be sought unless the delay in communicating with such person is, in the opinion of the physician, imprudent under the circumstances.

Signature: _____

Medical history

1. Is he/she allergic to any drug, insect bite, food or any substance? Yes No If yes, explain.
2. Is he/she taking any medication? Yes No What and why?
3. Is he/she suffering from any condition requiring special attention such as asthma, diabetes, epilepsy; cardiac condition, etc.? Yes No If yes, what is the condition?
4. Has he/she been under the care of a physician or hospitalized in the past year? Yes No If yes, when and why?
5. Does he/she have any physical disability or handicap? Yes No If yes, explain.