ARCHDIOCESE OF MILWAUKEE
Medical Information & Emergency Consent Form

Participant's Name: _____

Address: _____

City: _____ Zip: _____ Phone: _____

Parent/Legal Guardian(s): _____ _____

Address(s): _____ _____

Employer(s): _____ _____

Home Phone: _____ _____

Work Phone: _____ _____

MEDICAL INFORMATION:

Family Physician: _____ Phone:_____

Group/Address: _____

Hospital of Preference: _____

Insurance Subscriber: _____ Group #: _____

Policy #: _____ Company: _____

List any Medical Problems: _____

Allergies: _____

In the event of an injury or illness I/we grant permission to any and all health care providers designated by Northwest Catholic's volunteers or staff to provide my/our child _____ any and all necessary medical care related to the injury or illness. I/We further understand I/we 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.

Signed this _____ day of _____ 20__

_____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Signature