

ARCHDIOCESE OF MILWAUKEE
Medical Information & Emergency Consent Form

Participant's Name _____

Address _____

City _____ Zip _____ Phone _____

Parent / Legal Guardian _____

Address _____

Employer _____

Home Phone _____ Work Phone _____

MEDICAL INFORMATION:

Family Physician: _____ Phone _____

Group / Address _____

Hospital of preference: _____

Insurance Info: Subscriber: _____ Group #: _____

Policy #: _____ Company: _____

Medical problems: _____

Allergies: _____

In the event of an injury or illness I/we grant permission to any and all health care providers designated

by _____ 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 necessary information related to the medical emergency.

Signed this _____ day of _____ 20_____

Parent / Legal Guardian Parent / Legal Guardian