Lourdes Academy
Athletic Department
Medical Authorization Form

STUDENT INFORMATION:

Name:______________________________ Birth Date:______________

Address:______________________________ Grade:______ Gender:______

City, ST Zip:______________________________ Home Phone:______________

PARENT/GUARDIAN INFORMATION:

Name:______________________ Name:______________________

Relationship:______________________ Relationship:______________________

Home Telephone #:______________________ Home Telephone #:______________________

Work Phone #:______________________ Work Phone #:______________________

Mobile Phone #:______________________ Mobile Phone #:______________________

FOR EMERGENCY USE WHEN PARENT/GUARDIAN CANNOT BE LOCATED:

Name:______________________ Name:______________________

Relationship:______________________ Relationship:______________________

Telephone #:______________________ Telephone #:______________________

STUDENT HEALTH INFORMATION

Medical Conditions: (e.g. Asthma, Diabetes, Allergies, etc.):______________________________

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Current Medications (prescription & non-prescription):______________________________

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Primary Doctor:______________________ Preferred Hospital:______________________

MEDICAL AUTHORIZATION

I hereby authorize school authorities, in my absence, to have my child transported to the nearest hospital for medical treatment when necessary due to illness/injury and to release personally identifiable information regarding my child. I further authorize the hospital and its staff to provide any medical treatment needed in a medical emergency.

Parent/Guardian Signature:______________________________ **Date:**______________