LOURDES ACADEMY
Our children. Our faith. Our future.

ATHLETIC DEPARTMENT

EMERGENCY MEDICAL AUTHORIZATION

This form must be made available by the coach at all team practices and contests for each team member to ensure proper medical treatment by physicians or hospital in the event of serious injury.

ATHLETE NAME_____

BIRTH DATE _____ GRADE _____ GENDER _____

PARENT/GUARDIAN NAME(S) _____

PARENT/GUARDIAN TELEPHONE NUMBER(S) _____

ADDRESS/CITY/STATE/ZIP _____

In the event a parent/guardian cannot be contacted, please contact:

_____ at phone # _____

List the sports the above-named athlete plays: _____

_____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital/emergency room for treatment for any illness or injury resulting from his/her athletic participation.

PREFERRED PHYSICIAN _____

PREFERRED HOSPITAL _____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

Lourdes Academy (6-12)
110 N. Sawyer St., Oshkosh, WI 54902
Ph: 920-235-5670 Fax: 920-235-7453

Lourdes Academy - Cabrini (PK-5)
619 Merritt Ave., Oshkosh, WI 54901
Ph: 920-235-0637 Fax: 920-426-6429

Lourdes Academy - Seton (PK-5)
1207 Oregon St., Oshkosh, WI 54902
Ph: 920-235-4060 Fax: 920-426-6430