ACADEMY OF THE HOLY FAMILY

54 West Main Street * Baltic, Connecticut 06330 * Telephone: (860) 822-9272 * Fax: (860) 822-1318
School Nurse: Mrs. Cheryl L. Johnson, LPN * Email: schoolnurse@ahfbaltic.org

Medical Card for Coach

20___ - 20___

This form will accompany the athlete to the doctor or hospital if medical attention is required.

Student Name: _____Date of Birth: _____ Grade: _____

Allergies: _____ Medications: _____

Home Address: _____

Parent/Guardian Name #1: _____

Home #: _____ Work #: _____ Cell #: _____

Parent/Guardian Name #2: _____

Home #: _____ Work #: _____ Cell #: _____

If parent cannot be reached, person to be contacted in case of emergency.

Emergency Contact #1: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact #2: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Health Insurance Information

Name of Medical/Accident Insurance Company: _____ Phone: _____

Policy Holder Name: _____ Policy Holder SS#: _____

Policy Holder Date Of Birth: _____

Address of Policy Holder: _____

Policy No. _____ Group No. _____

Release for Treatment

In the event I cannot be reached, I hereby authorize and grant to the staff of Academy of the Holy Family School permission to administer or obtain medical care, perform any necessary treatments, and/or administer medication to my daughter. When necessary, I give my permission for the staff at Academy of the Holy Family to seek and obtain medical treatment for my daughter on an emergency or as needed basis at a licensed hospital, clinic and/or a licensed physician, nurse practitioner or physician's assistant.

Parent/Guardian Signature: _____ Date _____

Student Signature: _____ Date _____

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