

**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