SAINT MARY'S COLLEGE HIGH SCHOOL • 1294 Albina Street • Berkeley, CA 94706

2018 - 2019 HEALTH / EMERGENCY FORM

This form must be FULLY completed and signed by a parent/guardian AND physician EACH ACADEMIC YEAR to be enrolled at Saint Mary's College High School. All information is *REQUIRED*. *DO NOT LEAVE ANY SPACES BLANK* or form unsigned.

1. _____
   Student's Last Name First Name Initial
2. _____
   Address/City/State/Zip
3. Student's Date of Birth _____ Student's Cell Phone _____ Student's Home Phone_____
4. Father's Name: _____ Mother's Name: _____
   Father's Work Phone: _____ Mother's Work Phone: _____
   Father's Cell Phone: _____ Mother's Cell Phone: _____
5. Person who can be contacted in case of emergency (**other than parent or guardian**):
   _____ _____ _____
   Name Address/City/State Phone
6. _____
   Student's Physician/City/Phone
7. _____
   Hospital Preference
8. _____
   Student's Dentist/City/Phone
9. _____ _____
   MEDICAL INSURANCE CARRIER **MEDICAL INSURANCE I.D. NUMBER**

Primary subscriber name: _____

I give my consent for my child to participate in interscholastic high school sports at SMCHS: YES_____ NO_____
I give my consent for my child to participate in intramurals at SMCHS: YES_____ NO_____

In an emergency, if we cannot be reached, and our family physician is not available, I (we) hereby give Saint Mary's College High School permission to have the above student treated by a physician or the Saint Mary's College High School Athletic Trainer and to use the closest available medical facility. I hereby state that the information provided on this form is true and correct.

_____ _____ _____
PARENT'S NAME (print) **PARENT'S SIGNATURE** **Date**

*** TO BE COMPLETED BY STUDENT'S PHYSICIAN ***

Male / Female Age _____ Height _____ Weight _____ Blood Pressure _____ Glasses or Contacts? _____

Chronic illnesses such as asthma, diabetes, epilepsy, heart disease, etc.:

Allergies such as food, drugs, bites and stings, pollens, etc. (please indicate if Epi-Pen is needed):

Medications student is taking and for what reason (please include asthma inhalers):

Other physical problems (please list):

I hereby certify that I have examined the above-named patient and have found him/her physically fit to participate in:

Interscholastic high school sports: YES ____ NO ____
Intramurals: YES ____ NO ____

_____ _____ _____
Physician's Name (print) **Signature** **Date**

_____
Address, City, State Phone