

**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: \_\_\_\_\_

\_\_\_\_\_ to provide my/our child  
\_\_\_\_\_ Medical problems:

~~contacted as soon as practical as to the medical emergency and be provided with all necessary~~  
~~information I/we further understand I/we will be~~ any and all necessary medical care related to the injury

~~informed of the medical emergency.~~ Signed this \_\_\_\_\_ day of \_\_\_\_\_ In the

\_\_\_\_\_ 20\_\_\_\_\_  
event of an injury or illness I/we grant permission to any and all health care providers designated by

Parent / Legal Guardian Parent / Legal Guardian