

**C.Y.A.A. CONSENT FOR EMERGENCY CARE  
ST. THOMAS AQUINAS GRADE SCHOOL**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Parent Contact: \_\_\_\_\_

Address \_\_\_\_\_

Primary Contact Number \_\_\_\_\_

Secondary Contact Number \_\_\_\_\_

If unavailable, contact: \_\_\_\_\_

List any medical problems or allergies: \_\_\_\_\_

\_\_\_\_\_

BE IT KNOWN that I, the undersigned parent or guardian of the student above-named, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment, or care to said student, as in the judgment of said doctor or hospital, may be required on an emergency basis, in the event said student should be injured or stricken ill while participating in an interscholastic activity. IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing, and are intended throughout the current school year. IT IS FURTHER understood that any expenses incurred will be paid by insurance or the parent of the student. Payment of the expense is not a school responsibility.

DATED the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

|                                    |               |
|------------------------------------|---------------|
| _____<br>Parent/Guardian Signature | _____<br>Date |
|------------------------------------|---------------|

|                                    |               |
|------------------------------------|---------------|
| _____<br>Parent/Guardian Signature | _____<br>Date |
|------------------------------------|---------------|

Family Physician \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_