MEDICAL / EMERGENCY INFORMATION FORM

FAMILY NAME ___________________________________ PHONE ___________________

Student Name	Grade	Allergies
__________________________	___________	_________________________
__________________________	___________	_________________________
__________________________	___________	_________________________

Where can parent/guardian be reached if not at home during class hours?

Mother __________________________________ Phone __________________________

Father ___________________________________ Phone __________________________

Names of two (2) adults who will assume responsibility if parents cannot be reached:

Name _____________________ Phone _________________ Relationship ______________

Name _____________________ Phone _________________ Relationship ______________

Additional information that we need to know about your child/ren to be of help to him/her for example, learning disabilities, allergies, physical disabilities, medical problems etc.

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Name of Physician _______________________________ Phone _____________________

Medical Insurance Company ___________________________ Policy # ________________

MEDICAL RELEASE

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of the Director of Religious Education or other person responsible for the program/group, or other appropriate staff member, there is a necessity for immediate examination and /or treatment of my child, I (we) hereby authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.
Dates for which release is intended: **July 1, 2008 to June 30, 2009**

Parent Signature ____ Date ______________

Parent Signature ____ Date ______________