

**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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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, 2009 to June 30, 2010**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_