

MEDICAL & EMERGENCY NOTIFICATION INFORMATION / AUTHORIZATION FOR MEDICAL TREATMENT

Archdiocese of Chicago | 2011-2012 School Year

(PLEASE PRINT)

Student Name: _____

Date of Birth: _____ Grade: _____

List Medical Allergies and/or Significant Medical History: _____

Parent/Guardian: _____

Home Telephone: _____ Work Telephone: _____

Parent/Guardian: _____

Home Telephone: _____ Work Telephone: _____

Name of Student's Physician: _____

Address/City: _____ Telephone: _____

Insurance Company: _____ Policy Number: _____

Emergency Contact: _____ Relationship to Student: _____

Emergency Telephone 1: _____ Emergency Telephone 2: _____

Emergency Contact: _____ Relationship to Student: _____

Emergency Telephone 1: _____ Emergency Telephone 2: _____

Medical Release

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgement of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

This form will accompany students on field trips. It is the responsibility of the parent/guardian to update emergency information as necessary.

✕ _____
Parent/Guardian Signature Date

✕ _____
Parent/Guardian Signature Date