MEDICAL AND EMERGENCY NOTIFICATION INFORMATION

AUTHORIZATION FOR MEDICAL TREATMENT

ST. PATRICK SCHOOL **SCHOOL YEAR: 2019-2020**

STUDENT NAME	DATE OF BIRTH	CLASS	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT LEGIBLY

Parent/Guardian ________________________ Parent/Guardian _____________________________

Home Phone: (___)_______________________Home Phone: (___)___________________________

Work Phone: (___)________________________Work Phone: (___)___________________________

Cell Phone: (___)__________________________Cell Phone: (___)___________________________

Name of Student's Physician____

Physician's Phone # ____

Address: ____ City _____________________ State _____

Medical Insurance Provider_______________________ Policy/Insurance #_________________

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

Name: ______________________________________Relationship to Student: __________________

Phone 1 ( ) _______________________________ Phone 2 ( ) __________________________

Name: _______________________________________Relationship to Student: _________________

Phone 1 ( ) _______________________________ Phone 2 ( ) _________________________

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment 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.

____ Date: ____________________________

Parent/Guardian Signature

____ Date: ____________________________

Parent/Guardian Signature

THIS FORM WILL ACOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.