

To be completed by parent/guardian for each child and submitted to the school annually.

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION  
AUTHORIZATION FOR MEDICAL TREATMENT**

**ST. PATRICK SCHOOL**

**SCHOOL YEAR: 2010-2011**

| <b>STUDENT NAME</b> | <b>DATE OF BIRTH</b> | <b>GRADE</b> | <b>LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY</b> |
|---------------------|----------------------|--------------|--|
|                     |                      |              |  |

**PLEASE PRINT**

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.

\_\_\_\_\_  
Parent/Guardian Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

Date: \_\_\_\_\_

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