MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL St. Catherine – St. Lucy School SCHOOL YEAR 2016 - 2017

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

PLEASE PRINT

Parent/Guardian__________ Parent/Guardian__________

Home Phone ( ) _____ Work ( ) _____ Home Phone ( ) _____ Work ( ) _____
Cell Phone ( ) __________ Cell Phone ( ) __________

Name of Student's Physician __________ 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 ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.