St. Francis Xavier Religious Education

Medical Information / Authorization For Medical Treatment

Name:_____ **Grade (2017/2018):**_____

Medical Allergies / Significant Medical History (if applicable):_____

_____

Last Tetanus Immunization: _____

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Mother's Name _____ Home (____)_____Work (____)_____Cell Phone (____)_____

Father's Name _____ Home (____)_____Work (____)_____ Cell Phone (____)_____

Name of Physician: _____Phone( )_____

Address _____

Medical Insurance Company _____Insurance Policy Number_____

Other Contacts In Case Of Emergency:

Name _____ Phone ( ) _____ Relationship_____

Name _____Phone ( ) _____ Relationship _____

MEDICAL RELEASE:

In the event that the undersigned, or my (our) authorized physician cannot be reached and in the judgment of **TERRI SIMEONI** (name of 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 (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 agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Parent/Guardian Signature_____Date_____

Parent/Guardian Signature_____Date_____