

St. Francis Xavier Religious Education

Medical Information / Authorization For Medical Treatment

Name: _____

Grade (2018/2019): _____

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

Last Tetanus Immunization: _____

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 _____