

Medical/Emergency Information

Name of Child

(Children): _____

Medical Allergies/Significant Medical

History: _____

Father's Name: _____ **Home Phone:** _____

Mother's Name: _____ **Home Phone:** _____

Name of Physician: _____ **Phone:** _____

Address: _____

Medical Insurance Co: _____

Insurance Number: _____

Other Contact In Case of Emergency:

Name: _____ **Phone:** _____

Relationship: _____

Medical Release

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of Joe Sheehan, Coordinator of Religious Formation at St. Joan of Arc Church, or other appropriate staff member, if 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.

Dates for Which This Release is Intended: June 18th, 19th and 20th 2018

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____