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

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL: QUEEN OF THE ROSARY SCHOOL SCHOOL YEAR: ____________

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

PLEASE PRINT

Parent/Guardian:		Parent/Guardian:	
Home:	Work:	Home:	Work:
Cell:		Cell:	

Student's Physician:		Telephone:
Address:	City:	State:

Medical Insurance Provider:	Policy/Insurance #:

EMERGENCY CONTACTS IN CASE PARENT / GUARDIAN CANNOT BE REACHED:
(Please list names other than the parent/guardian)

Name:	Name:
Relationship to Student:	Relationship to Student:
Telephone 1: ________________ ☐cell ☐home ☐other	Telephone 1: ________________ ☐cell ☐home ☐other
Telephone 2: ________________ ☐cell ☐home ☐other	Telephone 2: ________________ ☐cell ☐home ☐other

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.

Archdiocese of Chicago
Office of Catholic Schools
June 2008