Catholic Archdiocese of Kansas City. KS

St. Aloysius Catholic Church

Annual Medical Release

Name of Student: ______________________________ **Date of Birth:** ______________

Address: ____

____________________________________ **Best Phone #:** __________________

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor and hospital. If you are unable to reach me, contact:

Emergency Contact: ______________________________ **Phone:** __________________

Relation to participant: ____________________________________

If you are unable to reach parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgement in treating my participant.

Medical/Hospital Insurance Carrier ____

Name of Policy Holder__________________________ Relation to Participant ____________

Policy Number ________________________ Group Number ________________________

Signature of Parent/Guardian ______________________________ Date ______________

Father/Guardian's full name: ____

Phone #: __________________________ **Cell #:** ______________________________

Home Address: ____

Place of Business/Address: ____

__________________________________ **Business Phone #:** ____________________

Father/Guardian's full name: ____

Phone #: __________________________ **Cell #:** ______________________________

Home Address: ____

Place of Business/Address: ____

__________________________________ **Business Phone #:** ____________________

Continued on next page/back.

Name of Participant ____

Medications: My child is taking the following medication(s)

Description: ____ Dosage: ____________________________

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(IF A MEDICATION NEEDS TO BE TAKEN IN THIS HOUR, EITHER A PHYSICIAN'S PERSCRIPTION OR A PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRECERITION/NOTE SHOULD BE ATTACHED TO THIS FORM.)

I hereby grant permission for non-prescription medications to be given (if deemed appropriate)

Acceptable non-prescription medications: ____

Drug allergies ____

____

Other allergies/reactions (food, plants, insects, etc.)_________________________________

____

List any other health problems / limitations that we need to be aware of ______________________

____

Signature of Parent / Guardian ____________________________________ **Date:** ____________________

(This medical Release is good for the period of one year, beginning _______________ **ending** ____________