

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT**

SCHOOL St. Theresa

SCHOOL YEAR 2010-2011

STUDENT NAME _____ DOB _____ GRADE _____

ADDRESS _____

Parent/Guardian _____ Parent/Guardian _____

Home Phone () _____ Work () _____ Home Phone () _____ Work () _____

Cell Phone () _____ Cell Phone () _____

MEDICAL HISTORY

Allergies(Foods, Medications, Environment, Insects): _____

Reaction to Allergies: _____

Medications/Dosage/Taken for: _____

Previous Surgery/ies or Hospitalizations: _____

My Child Wears: Glasses Contacts Braces Other

Name of Physician _____ Phone () _____

Address _____ City _____ State _____

Medical Insurance Provider _____ Policy# _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

Name _____ Relationship _____

Phone () _____ Phone () _____

Name _____ Relationship _____

Phone () _____ Phone () _____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgement 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