

To be completed by parent/guardian and submitted to the school annually (one per family).

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT
ST. MATTHIAS TRANSFIGURATION SCHOOL SCHOOL YEAR 2010-2011

PLEASE PRINT:

Date _____ / _____ / _____

STUDENT NAME (First, Middle, Last)	DATE OF BIRTH	SEX	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

Family Name _____ Home Phone _____

Primary Address _____ City, State & Zip _____

Name of Physician _____ Phone (____) _____

Address _____ City _____ State _____

Hospital of Choice _____

Medical Insurance Provider _____ Policy/Insurance # _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

The following individual/s have my/our permission to pick up my/our child/ren from school or Extended Care in my absence. In an event of emergency they may be contacted if I/we cannot be reached. I/we have listed additional individuals on reverse.

Contact 1

Name _____

Relationship _____

Home Phone (____) _____ Work (____) _____

Cell Phone (____) _____

Contact 2

Name _____

Relationship _____

Home Phone (____) _____ Work (____) _____

Cell Phone (____) _____

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, and there is a necessity for immediate examination and/or treatment of my/our child/ren, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child/ren 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

FAMILY NAME _____

(Side 2)

Father/Guardian

Mother/Guardian

First Name _____

Last Name _____

Address _____

City State Zip _____

Home Phone (____) _____

Home Phone (____) _____

Work Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Cell Phone (____) _____

Email _____

Email _____

Occupation _____

Occupation _____

Work Name _____

Work Name _____

Work Address _____

Work Address _____

Parents Marital Status _____ Married _____ Single

_____ Divorced _____ Separated _____ Widow

Student Lives With _____ Live more than 1.5 miles _____ Yes _____ No

Transportation to School _____

Closest Public School _____

Religion _____

Parish _____

Ethnicity _____

First Language _____

Primary Language Spoken at Home _____

Birth City & State _____

US Citizen _____ Yes _____ No

The following are also authorized to pick up my/our child/ren from school or Extended Care:

Contact 3

Contact 4

Name _____

Relationship _____

Home Phone (____) _____ Work (____) _____

(____) _____ (____) _____

Cell Phone (____) _____

(____) _____

Contact 5

Contact 6

Name _____

Relationship _____

Home Phone (____) _____ Work (____) _____

(____) _____ (____) _____

Cell Phone (____) _____

(____) _____