Catholic Archdiocese of Atlanta
St. Matthew Catholic Church
Annual Medical Release 2016-2017

Name of Student:____________________________________ **Date of Birth:**____________________

Address:____

____ **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 judgment in treating 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:____

____ **Phone #:** ________________

Mother/Guardian's full name:____

Phone #:____________________________ Cell # __________________________________

Home address:____

Place of business/address:____

____ **Phone #:**_________________

(Both sides need to be completed and signed)

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Name of Participant ____

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

Description ____ Dosage _____________________________________

Description ____ Dosage _____________________________________

(EITHER A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRESCRIPTION / NOTE SHOULD BE ATTACHED TO THIS FORM.)

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

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 _________________ and ending ______________.)