Catholic Archdiocese of Atlanta

Our Lady of the Assumption Catholic Church

Annual Medical Release – One per child

Name of Student: _____ Date of Birth: _____

Address: _____

_____ Home phone #:_____

Father/Guardian's full name: _____

Cell #: _____ Work #: _____

Home address: _____

Mother/Guardian's full name: _____

Cell #: _____ Work #: _____

Home address: _____

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 either parent, contact:

Emergency contact ***(Not either parent)***: _____

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: _____

Drug allergies: _____

_____

Medications: My child is taking the following medication(s): *[Please include each medicine and its dosage]*

_____

_____

(Both pages of this form must be completed and signed)

_____ By initialing here, I hereby grant permission for non-prescription medications (such as Ibuprofen, Tylenol, or Benadryl) to be given, if deemed appropriate.

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: **_____**

Parent/Guardian Printed Name: _____

(This Medical Release is good for the period of one year; beginning July 2019 and ending June 2020.)