

MEDICAL INFORMATION/PERMISSION AND RELEASE FORM
EFFECTIVE DATES: 2017/18 RE School Year

Name(s) of child/children

PARENTAL RELEASE

In signing this form, I hereby certify that the information below is correct and give permission for my child to be transported to a medical facility by emergency medical personnel in case of emergency. I give permission for the release of medical records to an attending physician in case of injury or illness.

I understand that every effort will be made to contact me before treatment is begun. In the event I cannot be reached, I hereby give permission to the physician attending my child to hospitalize and secure proper and necessary treatment for my child, as named herein.

I hereby agree that no liability is assumed by the Archdiocese of Boston, St. James Parish or its representatives, for claims which may arise out of this activity. I further understand that I will not hold St. James Parish/St. John the Baptist Parish or its Religious Education staff responsible for any injury caused by my child's failure to use common sense or abide by the rules and regulations of the parish programs.

Signature of Parent(s)/Guardian Date

Home Phone Father's cell phone Mother's cell phone

If I cannot be reached in an emergency, call Phone

Relationship of this person to the child:

INSURANCE INFORMATION

Insurance Carrier and Policy Number

Family Physician or Clinic Phone

If transportation to a medical facility is necessary, I prefer that my child be sent to: if by doing so the health and safety my child will not be compromised.

PLEASE LIST THE NAME OF EACH CHILD ON A SEPARATE LINE AND ANY MEDICATIONS THE CHILD TAKES AS WELL AS ANY ALLERGIES THE CHILD MAY HAVE.

Table with 3 columns: CHILD, MEDICATIONS, ALLERGIES. Multiple rows for data entry.