



# Emergency Medical Treatment Release Form

Required by all Parents/Guardians of Children Attending St. Mary Catholic School

A health form must accompany this form.

## Student Information:

Child's Name (First Student): \_\_\_\_\_

Child's Name (Second Student): \_\_\_\_\_

Child's Name (Third Student): \_\_\_\_\_

Child's Name (Fourth Student): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Parents/Legal Guardians Information:

Father's Name: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

## Student Health Information:

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Is the student listed in good health? #1  Yes  No #2  Yes  No #3  Yes  No #4  Yes  No

Date of last Tetanus Shot: #1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_ #4 \_\_\_/\_\_\_/\_\_\_

List allergies, medications or restrictions, by student: \_\_\_\_\_

## Health Insurance Information:

Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group: \_\_\_\_\_ Contract Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

## A neighbor or close relative who will assume care of your child if you cannot be reached:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_