

IMMACULATE CONCEPTION
PARISH RELIGIOUS EDUCATION PROGRAM (PREP)
MEDICAL INFORMATION: AUTHORIZATION FOR MEDICAL TREATMENT

Student's Full Name _____ Grade _____

Address _____

Medical Allergies/conditions: _____

Please list any needs you child may have so that we will be better able to serve him/her in class. For example: health, vision, hearing, education needs (A.D.D., A.D.H.D., L.D).

EMERGENCY CONTACT

Mother's Name _____ Home# _____ WK # _____ Cell _____

Father's Name _____ Home# _____ WK # _____ Cell _____

Name of Physician _____ PH# _____ Med. Ins: _____

Other Contact _____ PH# _____ Relationship _____

MEDICAL RELEASE

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of an Immaculate Conception staff member, there is a necessity for immediate examination and/or treatment of my (our) child. I (we) hereby request and authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Date or Dates for which release is intended: Sept. 2009 to August 2010

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____