

St. Thomas More Annual Medical Release

Name of Student: _____

Date of Birth: _____

Address: _____

Home 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 complete and signed)

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 _____.)