



**MEDICAL RELEASE AND  
EMERGENCY INFORMATION FORM**

STUDENT INFORMATION			
Child's Name:		Date of Birth:   mm/dd/year	
Physician's Name:		Telephone Number:	
Any chronic Health conditions:	Please provide Description	Please list all current medications:	Provide list of Medications
Environmental & Food Allergies:	Please provide Description	Educational & Behavioral Traits (e.g., gifted, ADD, dyslexic, etc.)	Please provide Description

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MEDICAL TREATMENT & INSURANCE INFORMATION			
Insurance Company:		Identification Number:	
Policy Number:		Group ID Number:	

***Please complete other side***  
***Emergency Medical Treatment Release***

I hereby authorize any reasonable and necessary medical treatment, administration of anesthesia, dental diagnosis, hospital and surgical treatment(s) for my minor child in the event of my absence, or when the hospital or physicians are *unable to contact me*. This authorization extends to any hospital, physicians, and nursing personnel on staff where treatment is rendered. I release from liability and waive all claims (with the exception of liability and claims resulting from gross negligence or willful misconduct) against St. Dunstan Catholic Church, church staff, church volunteers, the hospital, physicians, and nursing personnel for performing reasonable and necessary medical procedures in accordance with the authority of this consent for medical treatment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b><i>Pick-Up Authorization</i></b>		
In case of a medical emergency or a major disaster, all students will only be released to an individual AUTHORIZED to pick-up your child(ren) from their classes. Please provide us with the names of two designated persons other than a parent who may pick-up child(ren).		
Name:	Relationship to Child:	Phone No.
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