2018-2019 MEDICAL EMERGENCY AND RELEASE FORM – ST. JUDE RELIGIOUS EDUCATION
PLEASE PRINT CLEARLY

FAMILY LAST NAME: _____ E-mail: _____

Home Address:_____

Home Phone #: _____

Child(ren)s Name(s): _____

Mother's Name: _____ Father's Name:_____

Mother's day time phone: _____ Father's day time phone: _____

Mother's Cell/Mobile/Pager #: _____ Father's Cell/Mobile/Pager # _____

The following people may be called if parent(s) cannot be reached:

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Should the need arise, I give permission for my child(ren) to receive emergency medical care while participating in St. Jude Religious Education Program.

Family Doctor: _____ Phone #: _____

Insurance Co.: _____ Phone #: _____

Insurance Co. Policy #: _____ Group #:_____

Special medical, learning and/or physical needs (i.e.: food allergies, other allergies, medicines, asthma, diabetes, attention deficit, attention deficit hyperactivity, etc), of which you wish us to be aware. List child's name with information:

_____

_____

Medications taken on a regular basis, of which you wish us to be aware (list child's name with each medication)_____

_____

_____

I UNDERSTAND ONLY PARENTS AND THOSE INDIVIDUALS SO DESIGNATED MAY PICK UP MY CHILD(REN) FROM ST. JUDE RELIGIOUS EDUCATION PROGRAM. I understand that my child(ren) **need to be picked up promptly.**

Who normally will pick up your child(ren)? Mother _____ Father _____
Other designated individuals:

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

AUTHORIZATION SIGNATURE IS REQUIRED ON THIS FORM

Parent/Legal Guardian Signature: _____ **Date:** _____

FILL FORM IN COMPLETELY FOR YOUR CHILD(REN)'S SAFETY.