

2020-2021 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) and Birthdate(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: _____

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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: _____

AUTHORIZATION SIGNATURE IS REQUIRED ON THIS FORM

Parent/Legal Guardian Signature: _____ Date: _____

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