To be completed by parent/guardian
and submitted to the school annually.

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION / AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL: St. Elizabeth of the Trinity **School Year: ________________**

Student Name	Date of Birth	Grade	Medical Allergies and/or Significant Medical History

Parent/Guardian_________________________________ Parent/Guardian _________________________________

Home Phone_______________Work________________Home Phone________________Work ________________

Cell Phone_____________________________________Cell Phone _______________________________________

Name of Student(s) Physician_______________________________ Phone______________________________

Address____ City/State____________________________

Medical Insurance Provider_________________________________ Policy/Insurance # ____________________

EMERGENCY CONTACT IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME____RELATIONSHIP ___________________________________

Phone____ Alternate Phone ____________________________________

NAME____RELATIONSHIP ___________________________________

Phone____ Alternate Phone ____________________________________

MEDICAL RELEASE

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

____ DATE____________________

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.