

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: _____

Medical Allergies and/or

Student Name	Date of Birth	Grade	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.**