Annual Medical Release

Catholic Archdiocese of Atlanta / St. Benedict Catholic Church

Name of Participant: _____ **Date of Birth:**_____

Address: _____

_____ **Home Phone #:**_____

Participant's Social Security Number: _____ (Required for treatment in most Hospitals.)

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor and hospital. If you are unable to reach me, contact:

Emergency Contact: _____ **Relationship:** _____

Phone #'s: _____

If you are unable to reach a parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgment in treating participant.

Medical/Hospital Insurance Carrier: _____

Name of Policy Holder: _____ **Relationship:** _____

Date of Birth of Insured: _____ **Policy Number:** _____ **Group Number:** _____

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

Father/Guardian Full Name: _____ **Date of Birth:**_____

Social Security Number: _____ **Phone #'s:** _____

Home Address: _____

Place of Business/Address: _____ **Phone #:** _____

Mother/Guardian Full Name: _____ **Date of Birth:**_____

Social Security Number: _____ **Phone #'s:** _____

Home Address: _____

Place of Business/Address: _____ **Phone #:** _____

Medications: My child is taking the following medication(s)

Description: _____ **Dosage:** _____

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(A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS AND BE ATTACHED TO THIS FORM IF THIS MEDICATION WILL BE TAKEN AT A ST. BENEDICT SPONSORED EVENT.)

I hereby grant permission for non-prescription medications to be given, if deemed necessary.

Drug or other allergies/reactions (food, plants, insects, etc): _____

List any other health problems/limitations: _____

_____

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

(This Medical Release is valid for one year; beginning on date above)