



St. Matthew's Church Medical Information Retreat Form

Full Name: _____

Address: _____ City: _____ State/Zip: _____

Birth date of Child: _____

Parent/Guardian Name(s): _____

Home Phone: _____ Cell Phone: _____

Child's Physician: _____ Phone: _____

Date of last Tetanus shot: _____

Insurance Company: _____ Policy #: _____

Name of Policyholder: _____

Any drug or food allergies: _____

Special Deeds (including dietary): _____

If I cannot be reached, please contact: _____

Phone: _____ Relationship: _____