

CHURCH OF SAINT MARY - MEDICAL INFORMATION FORM

STUDENT'S NAME:

FOR JUNE 1, 2005 TO OCTOBER 1, 2006

_____ Date of Birth: ___/___/___ Age: ___ Sex: ___
(Last Name) (Middle Name) (First Name)

School _____ Grade: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian: _____ Phone: _____ Cell Phone: _____

Other Emergency Contact: _____ Phone: _____

PERMISSION FOR PRESCRIBED MEDICATION

List any medications being taken at this time. *(If more space is needed, list on reverse side of this form)*

Name of Medication: _____ Form: tablet/capsule/liquid/inhaler/injection/nebulizer

Reason for Medication: _____

Instructions (schedule and dose to be given at parish: program): _____

Start date: _____ End date: _____ Other: _____

Restrictions and/or important side effects: _____

Special Storage requirements: _____ Student may carry medication: No ___ Yes ___

Student is both capable and responsible for self-administering medication: No ___ Yes-Unsupervised ___ Yes-Supervised ___

I give permission for (name of child) _____ to receive the above medication at the parish program according to standard parish policy. (Some parishes require parent/guardian to bring the medication in its original container.)

Signature of

Parent/Guardian: _____ **Relationship:** _____

OTHER INFORMATION

Date of Last Tetanus Booster: _____

List any allergies: _____

List any medical conditions/pertinent health information we should be aware of: _____

INSURANCE/PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Carrier: _____ Policy Number: _____

RELEASE

In case of an emergency and parents/guardians cannot be reached, an ambulance or emergency personnel will be notified. Payment for medical emergencies is the responsibility of the parents/guardians.

Signature of

Parent/Guardian: _____ **Date:** _____

MEDFORM.WPDcolor printer

ONE FORM REQUIRED PER CHILD