Immaculate Heart of Mary Catholic Church

PSR/Middle School/High School MEDICAL RELEASE

(Please list your child(ren) on the back of this form)

PLEASE PRINT

Parent/Guardian Name:____

Home Address: ____

City: ____________________ State: ______________ Zip Code: ___________

Home Phone: ___________________Work: ___________________ Cell: _________________

EMERGENCY MEDICAL TREATMENT: In case of an emergency, I hereby give Permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment from the hospital or doctor. If you are unable to reach me, please contact:

Name: ____

Home Phone: _____________________ Work: _______________ Cell: ______________

Medical/Hospital Holder: ____

Relationship to participant: ____

Policy #: __________________________ Group # ________________________________

Doctor's Name: ______________________________ Phone #: ______________________

Dentist's Name: ______________________________ Phone #: ______________________

Signature: ____ Date: ________________

Please notify us if any information changes

Revised 7/17/07

CHILD/PARTICIPANT NAME: ____

My child is taking the following medications(s):

Descriptions: ____ Dosage: ____________________

____ Dosage: ____________________

Drug Allergies: ____

Other Allergic Reactions (foods, plants, insects, etc.) _______________________________________

Does your child have any physical limitations or any medical conditions we should be aware of?

____

. . . .

CHILD/PARTICIPANT NAME: ____

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Other Allergic Reactions (foods, plants, insects, etc.) ____

Does your child have any physical limitations or any medical conditions we should be aware of?

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