2016-2017 St. Peter Chanel Medical Release Form

I give permission to seek any emergency care should my child be involved in any accident or be injured in any way during such events. I understand that any such instance, all attempts will be made to contact the parent/guardian. In the event that I cannot be contacted, I hereby give permission to the attending physician to hospitalize, secure treatment for, and to order injection, anesthesia, and/or surgery for my child, as named herein.

Name of Minor: _____Date of Birth: _____

Name of Minor: _____Date of Birth: _____

Name of Minor: _____Date of Birth: _____

Name of Minor: _____Date of Birth: _____

Address: _____

Home Phone #: _____

Father/Guardian's Full Name: _____

Cell Phone #:_____

Home Address: _____

Place of business/address: _____

_____Phone #: _____

Mother/Guardian's Full Name: _____

Cell Phone #:_____

Home Address: _____

Place of business/address: _____

_____Phone #: _____

Relative or friend to contact if unable to reach parent/guardian in the event of emergency:

Name & Relationship: _____

Phone #: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Insurance Carrier: _____

Insurance Policy Number: _____

Insurance is provided by which parent and/or place of employment: _____

Address of Insurance Company: _____

_____Phone #: _____

Special consideration to be aware of (i.e. allergies, medical conditions, etc.): _____

_____

_____

Medication (and dosage) my child is currently taking: _____

_____

Parent please print name:

_____

Parent Signature: _____

Date: _____