

St. Mary Catholic Church

Parent / Guardian Medical Release

89 St. Mary's Place, Bunnell, Florida 32110 * Office Phone: (386) 437-5098 – Fax: (386) 437-5091

Name of Child: _____ Date of Birth: _____

Name of Parent/Guardian: _____

Home Address: _____ Home Phone: _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Of the following statements pertaining to medical matter, sign only in accordance with your wishes.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to St. Mary's employees, volunteers, or representatives to seek medical treatment for my child above named.

In the event that I can not be reached in an emergency, I hereby give permission to the physician selected by St. Mary's representatives or volunteers to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child above named.

In the event of an emergency, if you are unable to reach me at the above number, contact:

NAME & RELATIONSHIP: _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

FAMILY HEALTH PLAN CARRIER: _____ POLICY #: _____

I make the following exceptions: _____

My child's medications/dosages and or physical disabilities:

Medication: _____ Dosage: _____ Doctor: _____

Medical Problem/Condition: _____

Symptoms: _____

Medication: _____ Dosage: _____ Doctor: _____

Medical Problem/Condition: _____

Symptoms: _____

Physical Disabilities: _____

(Parent/Guardian/Representative Signature) _____ Date: _____

OTHER MEDICAL TREATMENT: In the event it comes to the attention of St. Mary's representatives or volunteers that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

(Parent/Guardian/Representative Signature) _____ Date: _____