Archdiocese of Chicago Office of Catholic Schools

To be completed by parent/guardian for each child and submitted to the school annually, and updated immediately as needed.

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

STUDENT	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian_____ Parent/Guardian_____
Home Phone ( )_____ Work( )_____ Home Phone ( )_____ Work ( )_____
Cell Phone ( )_____ Cell Phone ( )_____

Name of Student's Physician_____ Phone ( )_____

Address_____ City_____ State_____

Medical Insurance Provider_____ Policy/Insurance#_____

Diabetes Care Plan Submitted (if applicable): YES/NO
Asthma Action Plan Submitted (if applicable): YES/NO
Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form Submitted (if applicable): YES/NO

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME_____ RELATIONSHIP TO STUDENT _____
Phone 1 ( )_____ Phone 2 ( )_____

NAME_____ RELATIONSHIP TO STUDENT _____
Phone 1 ( )_____ Phone 2 ( )_____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her designee, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize school personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the medical and liability insurance coverage and costs for any diagnosis/treatment and/or for medication deemed necessary. I/We understand that it may be necessary for my/our child's medical condition to be disclosed to school personnel and/or medical providers and I/we expressly consent to such disclosure.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

THIS FORM SHALL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.