Catholic Archdiocese of Kansas City. KS

St. Aloysius Catholic Church

Annual Medical Release 2024-2025

Name of Student: _____ **Date of Birth:** _____

Address: _____

_____ **Best Phone #:** _____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor and hospital. If you are unable to reach me, contact:

Emergency Contact: _____ **Phone:** _____

Relation to participant: _____

If you are unable to reach parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgement in treating my participant.

Medical/Hospital Insurance Carrier _____

Name of Policy Holder_____ Relation to Participant _____

Policy Number _____ Group Number _____

Signature of Parent/Guardian _____ Date _____

Father/Guardian's full name: _____

Phone #: _____ **Cell #:** _____

Home Address: _____

Place of Business/Address: _____

_____ **Business Phone #:** _____

Mother/Guardian's full name: _____

Phone #: _____ **Cell #:** _____

Home Address: _____

Place of Business/Address: _____

_____ **Business Phone #:** _____

Continued on back of page – or page 2

Name of Participant _____

Medications: My child is taking the following medication(s)

Description: _____ Dosage: _____

Description: _____ Dosage: _____

(IF A MEDICATION NEEDS TO BE TAKEN IN THIS HOUR, EITHER A PHYSICIAN'S PERSCRIPTION OR A PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRECERITION/NOTE SHOULD BE ATTACHED TO THIS FORM.)

I hereby grant permission for non-prescription medications to be given (if deemed appropriate)

Acceptable non-prescription medications: _____

Drug allergies _____

_____

Other allergies/reactions (food, plants, insects, etc.)_____

_____

_____

Signature of Parent / Guardian _____ **Date:** _____

(This medical Release is good for the period of one year, beginning Sept 2024 ending Aug 2025