

To be completed by parent/guardian and submitted to the school annually.  
Include information for each child in the top section.

## MEDICAL AND EMERGENCY NOTIFICATION INFORMATION AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL: POPE FRANCIS GLOBAL ACADEMY

SCHOOL YEAR: 2019-2020

STUDENT(S) NAME	<u>DATE OF BIRTH</u>	<u>GRADE</u>	<u>LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY</u>

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 # \_\_\_\_\_

### EMERGENCY CONTACT IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

### 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 authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child(ren), I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child(ren) such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or any medication deemed necessary.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent must print out completed form, sign and return hard copies to the office.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent must print out completed form, sign and return hard copies to the office.

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