

ST. JAMES CATHOLIC CHURCH 505 WOODCREST AVE LITITZ PA 17543

Please Print: MEDICAL AUTHORIZATION FORM (one for each child)

Child's Name _____ Date of Birth _____ Age ____ Grade ____
Last First M

Father's Name _____ Mother's Name _____ Maiden Name _____

Address _____ Home Phone _____

Live With: Mother ____ Father ____ Both ____

Email _____ Mother's Cell _____ Father's Cell _____

Mother's Business Address _____ Business Phone _____

Father's Business Address _____ Business Phone _____

Medical Insurance Carrier _____ Policy Number: _____

Please use the reverse side of this form if additional space is needed to convey information.

ALLERGIES: _____

Physical condition that is limiting: _____

Any **surgery, injury or illness** (serious) within last year: _____

Medication prescribed by a physician to be taken regularly? _____

Learning Disabilities/Challenges: _____

Additional challenges not covered by above: _____

Name of Physician _____

Physician's Address _____ **Physician's Phone** _____

If I cannot be reached in the event of an emergency, the following person is authorized to act for me.

Name & Address _____

Relationship to Participant _____ Phone (____) _____

PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT

(Sign only one place below)

In case of medical emergency, I understand every effort will be made to contact parents of the child. In the event I cannot be reached, I hereby give permission to the physician selected by St. James Catholic Church to hospitalize, secure treatment for, and to order injection, anesthesia or surgery for my child as named above.

Signature of Parent _____ Date _____

Address _____ Phone _____

SIGN BELOW ONLY IF YOU DECLINE TO SIGN THE RELEASE ABOVE

I have been offered the opportunity to authorize emergency medical care as above set forth and decline to so authorize said medical emergency care without my approval and accept such complications as may occur should said medical care be needed and unavailable due to my being unavailable to provide the same.

Signature of Parent _____ Date _____

Address _____ Phone _____

PLEASE COMPLETE AND RETURN THIS FORM TO THE RELIGIOUS EDUCATION OFFICE at time of registration for classes. Resubmission of Medical Form is required when any information on a previously submitted form has changed.