To be completed by parent/guardian for each child and submitted to the school annually

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL St. Gerald School SCHOOL YEAR 2024-2025

STUDENT NAME	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 # _____

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

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

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

Archdiocese of Chicago
Office of Catholic Schools
June 2008