Catholic Archdiocese of Atlanta

St. John Neumann Catholic Church
Life Teen Annual Medical Release

Name of Student:______________________________ **Date of Birth:**______________________________

Street Address:______________________________

City/State/Zip:______________________________ **Phone Number:**______________________________

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 parent/guardian, contact the following person:**

Emergency contact:______________________________ Phone Number:______________________________

Relation to student:______________________________

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

Medical / Hospital Insurance Carrier:____

Name of Policy Holder:______________________________ Relation to student:______________________________

Policy Number:______________________________ Group Number:______________________________

Father/Male Guardian's full name:____

Phone Number:______________________________ Secondary:______________________________

Address (If Different):______________________________ City/State/Zip:______________________________

Employer Name/Address:____

Employer City/State/Zip:______________________________ Work Phone: ____________________

Mother/Female Guardian's full name:____

Phone Number:______________________________ Secondary:______________________________

Address (If Different):______________________________ City/State/Zip:______________________________

Employer Name/Address:____

Employer City/State/Zip:______________________________ Work Phone: ____________________

* * * * *

Signature of Parent/Guardian:______________________________ **Date:**____________________

PLEASE BE SURE TO COMPLETE THE BACK/SECOND PAGE!

Name of Student (complete if non-two sided printout):____

My child is taking the following ***medication(s)*** (Please write N/A on the first line if none):

Description:______________________________________ Dosage:__________________________________

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Description:______________________________________ Dosage:__________________________________

(EITHER A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRESCRIPTION / NOTE SHOULD BE ATTACHED TO THIS FORM.)

Drug allergies (Please write NKA if none known):____

____

Other allergies / reactions (food, plants, insects, etc.; Please write NKA if none known):____________________________

____

List any ***other health problems / limitations*** that we need to be aware of:_______________________________________

____

By **signing below**, I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

Signature of Parent / Guardian:_____________________________ Date:_____________________

For Office Use Only:
(This Medical Release is good for the period of one year; beginning __________________ and ending ______________.)