Catholic Archdiocese of Atlanta
Saint John Neumann Preschool
Annual Medical Release

Name of Student:_____ Date of Birth:_____

Address:_____ City_____ State_____ Zip_____

Home 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's Name:_____ Phone:_____

Relationship to participant _____

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

Medical / Hospital Insurance carrier _____

Name of Policy Holder _____ Relationship to participant_____

Policy Number_____ Group Number_____

Signature of Parent / Guardian _____ Date: _____

Father / Guardian's full name:_____

Home Phone #_____ Cell Phone #: _____

Address_____ City_____ State_____ Zip_____

Place of business & business address_____

_____ Business phone_____

Mother / Guardian's full name _____

Home Phone # _____ Cell Phone # _____

Address _____ City_____ State_____ Zip_____

Place of business & business address_____

_____ Business phone_____

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

Description:_____ Dosage:_____

Description:_____ Dosage: _____

Name of participate_____

Drug allergies_____

Other allergies_____

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

_____

Signature of Parent / Guardian _____ Date_____

This Medical release form is good for the period of one year; beginning_____ to _____