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:____

Cell Phone #: _____________________________________ Business Phone #:_______________________________

Address____ City_______________________ State______ Zip__________

Mother / Guardian's full name ____

Cell Phone # __________________________________ Business Phone #:______________________________________

Address ____ City________________________ State______ Zip__________

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

Description:____ Dosage:____

Description:____ Dosage: ____

Drug allergies____

Other allergies____

List any other health problems / limitations that we need to be aware of: (Continue on back if necessary)___________________
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This Medical release form is good for the period of one year; beginning__________________ **to** __________________