

**ST. CECILIA
CENTER FOR RELIGIOUS EDUCATION
MEDICAL INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT**

MEDICAL / EMERGENCY INFORMATION

(One form for each child, please)

Name	Level	Medical allergies/significant medical history	Last tetanus immunization

Mother's Name _____ Home # _____ Cell/
Business # _____

Father's Name _____ Home # _____ Cell/
Business # _____

Best Number for Wednesday class time in case of an emergency: _____

Name of Physician _____ Phone # _____

Address _____

Medical Insurance Company _____

Insurance Number _____

Other contact in case of an emergency:

Name _____ Phone _____

Relationship _____

MEDICAL RELEASE

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of Lisa Mersereau or other appropriate staff member or her designated adult leader 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 agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Date or Dates for which release is intended: September 2017 through May 2018

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

(A copy of this form will be accessible to the Catechist and the Front Desk Assistant.)