

ANNUAL MEDICAL RELEASE FORM

PARISH/SCHOOL: Our Lady of Mount Carmel

PARTICIPANT'S NAME: _____

Sex _____ **Date of Birth** _____ **Soc Sec #** _____

Home Address _____

City _____ **State** _____ **Zip** _____

Home Phone (____) _____ **Work** (____) _____

NAME OF PARENT/GUARDIAN: _____

Insurance

Company: _____

Policy Holder's Name: _____

Relationship to Policy Holder: _____

Policy Number: _____

In case of an emergency

notify: _____

Home Phone (____) _____ **Work** (____) _____

Medical Information

1) Does your child have any allergies? ____ YES ____ NO

If "YES," please list

2) Does your child have medication of any type with them?

If "YES," please list

3) Is there any other physical or emotional condition of which we need to be aware? Please explain.

In the event of any emergency, I give authority to the accompanying adults to authorize treatment. I understand that an attempt to notify me will be made before any treatment is authorized.

PARENT/GAURDIAN SIGNATURE:

_____ **Date** _____