MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

To be completed by parent/guardian for **each child** and submitted to the school annually.

Please submit a separate form for each child.

SCHOOL: St. Christina **School Year:** 2026/2027

STUDENT NAME	Date of Birth	Grade	List medical allergies and/or Significant medical history. Please include any emergency medications. (i.e. Epipen/Inhaler)

Please print

#1. Parent/Guardian _____ #2. Parent Guardian _____

#1. Cell Phone ( ) _____ Work ( ) _____

#2. Cell Phone ( ) _____ Work ( ) _____

Name of Student's Physician _____ Phone ( ) _____

Address _____ City _____ Zip _____

Medical Insurance Provider _____ Policy # _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

Name _____ **Relationship to student** _____

Phone # 1 ( ) _____ **Phone#2 ( )** _____

Name _____ **Relationship to student** _____

Phone #1 ( ) _____ **Phone #2 ( )** _____

MEDICAL RELEASE

In the event that the undersigned or my/our authorized physician cannot be reached and in the judgment of the School Principal or his/her authorized staff member, 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/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.