



Catholic Archdiocese of Atlanta
Saint Brigid Catholic Church
September 2023-September 2024
Annual Medical Release



Name of Student: _____ Date of Birth: _____

Address: _____

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 _____ Phone # _____

Relation to participant _____

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

Medical / Hospital Insurance Carrier _____

Name of Policy Holder _____ Relation to participant _____

Policy Number _____ Group Number _____

Father/Guardian's full name: _____

Phone #: _____ Cell # _____

Home address: _____

Place of business/address: _____

Mother/Guardian's full name: _____

Phone #: _____ Cell # _____

Home address: _____

Place of business/address: _____

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

Description _____ Dosage _____

Description _____ Dosage _____

(Either a physician's prescription or parent note must accompany all medications. Prescription /note should be attached to this form.)

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

Drug allergies _____

Other allergies / reactions (food, plants, insects, etc.) _____

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

Signature of Parent / Guardian _____ **Date** _____