

**DIOCESE OF MEMPHIS
HEALTH AND MEDICAL RELEASE FORM
Please fill out one per student**

Student Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Home Address: _____

Parent/Guardian: _____

Work Phone: _____ (mom) Cell Phone: _____ (dad) Cell Phone _____

If a parent or guardian cannot be reached in an emergency, then please notify:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

HEALTH HISTORY

List any pre-existing or present medical conditions: _____

List name and dosage of any medication taken on a regular basis: _____

List any allergies to medications: _____

List any other allergies: _____

Please specify if the student is under any special medical treatment or diet: _____

Any activity restrictions? ___ no ___ yes-please list _____
Date of last tetanus shot: _____ Wears contact lenses: ___ yes ___ no

Check if any of the conditions are present:

___ Hay fever

___ Heart condition

___ Allergic to insect stings

___ Diabetes

___ Frequent stomach upsets

___ Asthma

___ Epilepsy/nervous disorders

___ Any major illness/surgery in the past

___ Hearing/vision loss

___ Food Allergies

If any of the above conditions are checked, please give details: _____

In the case of a medical or surgical emergency, I hereby give permission to the physician selected by Saint Ann School or its representative to hospitalize and/or secure proper medical treatment for the above named student. I understand that I am responsible for the cost of any medical treatments, including surgery, received by my child. I understand that I will be contacted immediately in the case of a health emergency involving my child.

Signature: _____ Date: _____

Insurance Company: _____

Policy Number/Group Number: _____