

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION  
 AUTHORIZATION FOR MEDICAL TREATMENT**

Child's Room # \_\_\_\_\_

SCHOOL St. Hubert School

SCHOOL YEAR 2009-2010

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Name of Student's Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Medical Insurance Provider \_\_\_\_\_ Policy/Insurance # \_\_\_\_\_

**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.