



Catholic Archdiocese of Atlanta
Our Lady of the Assumption Catholic Church

Annual Medical Release – One per child

Name of Student: _____ Date of Birth: _____
Address: _____
_____ Home phone #: _____

Father/Guardian's full name: _____
Cell #: _____ Work #: _____
Home address: _____

Mother/Guardian's full name: _____
Cell #: _____ Work #: _____
Home 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 either parent, contact:

Emergency contact (*Not either parent*): _____

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 _____

Drug allergies: _____

Medications: My child is taking the following medication(s): *[Please include each medicine and its dosage]*

_____ By initialing here, I hereby grant permission for non-prescription medications (such as Ibuprofen, Tylenol, or Benadryl) to be given, if deemed appropriate.

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: _____

Parent/Guardian Printed Name: _____

(This Medical Release is good for the period of one year; beginning July 2020 and ending June 2021.)