

Catholic Archdiocese of Atlanta  
Parish name: \_\_\_\_\_

**Annual Medical Release**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Home phone #: \_\_\_\_\_

**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 \_\_\_\_\_

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Father/Guardian's full name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Cell #** \_\_\_\_\_

**Home address:** \_\_\_\_\_

**Place of business/address:** \_\_\_\_\_

\_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Mother/Guardian's full name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Cell #** \_\_\_\_\_

**Home address:** \_\_\_\_\_

**Place of business/address:** \_\_\_\_\_

\_\_\_\_\_ **Phone #:** \_\_\_\_\_

**(Both sides need to be complete and signed)**

Name of Participant \_\_\_\_\_

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 \_\_\_\_\_

(This Medical Release is good for the period of one year; beginning \_\_\_\_\_ and ending \_\_\_\_\_.)