

St. Gabriel the Archangel Parish
Office of Faith Formation
Medical Information/Permission and Release Form

First & Last Names of child/children: _____

Parent/Guardian Release

In signing this form, I hereby certify that the information below is correct and give permission for my child to be transported to a medical facility by emergency medical personnel in case of emergency. I give permission for the release of medical records to an attending physician in case of injury or illness.

I understand that every effort will be made to contact me before treatment is begun. In the event I cannot be reached, I hereby give permission to the physician attending my child to hospitalize and secure proper and necessary treatment for my child, as named herein. I hereby agree that no liability is assumed by the Archdiocese of Boston, St. Gabriel the Archangel Parish or its representatives for claims which may arise out of this activity. I further understand that I will not hold St. Gabriel the Archangel Parish or its Faith Formation staff responsible for any injury caused by my child(ren)'s failure to use common sense or abide by the rules and regulations of the collaborative programs.

Signature of Parent(s)/Guardian(s): _____ Date: _____

Home Phone: _____ Father's Cell #: _____ Mother's Cell #: _____

If I cannot be reached in an emergency, call: _____ Phone: _____

Relationship of this person to the child(ren): _____

Insurance Information

Insurance Carrier: _____ Policy Number: _____

Family Physician or Clinic: _____ Phone: _____

If transportation to a medical facility is necessary, I prefer that my child(ren) be sent to: _____ if, by doing so, the health and safety of my child(ren) will not be compromised.

Please list each child on a separate line and any medications the child takes as well as any allergies the child may have.

<i>Child</i>	<i>Medication(s)</i>	<i>Allergies</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____