

ST. MARY'S & ST. MATTHEW FAITH COMMUNITY - FAMILY HEALTH FORM

Family Name _____ Family Physician/Clinic _____
Phone Number _____

Health Insurance Co _____ Policy Number _____

Who should be notified in case of emergency if parent cannot be reached?
Name _____ Phone Number _____

Is there anyone to whom the child(ren) cannot be released?

Name **Phone Number** **Relationship**

1) Name _____ Please list any allergies or special medical condition _____
Medication(s) _____

2) Name _____ Please list any allergies or special medical condition _____
Medication(s) _____

3) Name _____ Please list any allergies or special medical condition _____
Medication(s) _____

4) Name _____ Please list any allergies or special medical condition _____
Medication(s) _____

In signing this health form, I hereby certify that the above information is correct and give permission for the release of medical records to an attending physician in case of illness. In case of medical emergency, I understand that every effort will be made to contact the parents or guardian. In the event that I cannot be reached, I hereby give permission to the physician selected to secure proper treatment for my child(ren) named herein.

Signature of parent/guardian

Phone Number

Date