

**ST. MARY'S & ST. MATTHEW PARISH CLUSTER - 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