Catholic Archdiocese of Atlanta

Our Lady of the Mountains Roman Catholic Church
1908 Waleska Hwy
Jasper, GA 30143

Annual Medical Release

Name of Student(s):_____**Date(s) 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(s) _____

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(s).

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 completed and signed)

Name of Participant (s)_____

Medications: My child is taking the following medication(s):

Description _____ Dosage _____

Description _____ Dosage _____

Description _____ Dosage _____

Description _____ Dosage _____

Description _____ Dosage _____

Description _____ Dosage _____

(EITHER A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS/ PRESCRIPTIONS. THE NOTE SHOULD BE ATTACHED TO THIS FORM.)

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.
List here what may be given and to whom:

_____

_____

_____

_____

_____

_____

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 August 9, 2015 and ending August 8, 2016.)