EMERGENCY CONTACT AND MEDICAL RELEASE FORM
St. Christopher Religious Education Program

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL, ALLERGIES AND/OR SIGNIFICANT MEDICAL HISTORY

Emergency Contact Numbers

Parent/Guardian 1:

Name_____
Home: _____
Work:_____
Cell:_____

Parent/Guardian 2:

Name_____
Home: _____
Work: _____
Cell:_____

If Parents cannot be reached who should we call?
Name_____PhoneNumber_____Relationship_____

General Permission: I/We the parent(s)/guardian(s) of the student(s) named above, hereby release and hold harmless St. Christopher Parish / St. Christopher School / St. Christopher Religious Education and any and all of its employees and volunteers from any and all liability to my/our child as the result of attending classes at our facility, or at any school sanctioned field trips/retreats.

Parent /Guardian Signature_____Date_____

Medical Insurance Provider: _____Policy #:_____

☐**Medical Consent**: Please sign this section, if after reasonable attempts to reach you have been unsuccessful, you give your consent for 1) any treatment deemed medically necessary; 2) treatment by any licensed physician if those listed below cannot be reached and if treatment would be compromised by delay. I agree to assume the financial responsibility for diagnosis/treatment and/or for medication deemed necessary.

Parent/Guardian Signature_____
Preferred Physician _____ **Phone**_____
Preferred Dentist _____ **Phone**_____

OR…

☐**Refusal to Give Consent:** I DO NOT give my consent to emergency medical treatment for any child. In the event of illness or injury requiring emergency treatment, if we cannot be reached, I wish the authorities to take NO ACTION

Parent/Guardian Signature: _____

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY