Corpus Christi Faith Formation

Medical Release Form & Liability Waiver 2019-2020

This form may be used for up to 3 Children – Signature Required on Back
Turn in with Registration

Family Last Name: _____

Address: _____State: _____ Zip: _____

Cell: (_____) _____- _____ Email: _____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

Emergency Contact Information: If you are unable to reach me, please contact:

Name: _____Phone: _____

Family Doctor: _____ Phone: (___) _____-_____

Family Health Plan Carrier: _____

Policy Number: _____ Effective Date: _____/_____/_____

Medical Matters: I hereby warrant that to the best of my knowledge, my child(ren) is/are in good health, and I assume all responsibility for the health of my child(ren).

Other Medical Treatment: You will be contacted in the event that your child becomes ill with symptoms of a headache, vomiting, sore throat, fever, or diarrhea.

#1 Student Information

Student Full Name: _____

Date of Birth: _____-_____-_____ Age _____ Grade: ___ Height: Ft./in. _____Weight: _____lbs.

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence. Special medical conditions, allergies, and medications:

_____ _____

Immunizations (current?)___Yes ____No, Wears contacts or glasses? ___Yes ____No

Special Needs: (Medical, Learning Disabilities, Physical Disabilities, etc.):

_____

_____I hereby grant permission for non-prescription medication (such as aspirin, Tylenol, throat lozenges) to be given to my child, if deemed appropriate.

_____No medication of any type, whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

#2 Student Information

Student Full Name: _____

Date of Birth: _____-_____-_____ Age _____ Grade: ___ Height: Ft./in. _____Weight: _____lbs.

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence. Special medical conditions, allergies, and medications:

_____

Immunizations (current?) ___Yes ____ No Wears contacts or glasses? ___Yes ____No

Special Needs: (Medical, Learning Disabilities, Physical Disabilities, etc.):

_____

_____I hereby grant permission for non-prescription medication (such as aspirin, Tylenol, throat lozenges) to be given to my child, if deemed appropriate.

_____No medication of any type, whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

#3 Student Information

Student Full Name: _____

Date of Birth: _____-_____-____ Age _____ Grade: ___ Height: Ft./in. _____Weight: ___lbs.

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence. Special medical conditions, allergies, and medications:

_____

Immunizations (current?) ___Yes ____ No, Wears contacts or glasses? ___Yes ____No

Special Needs: (Medical, Learning Disabilities, Physical Disabilities, etc.):

_____

_____I hereby grant permission for non-prescription medication (such as aspirin, Tylenol, throat lozenges) to be given to my child, if deemed appropriate.

_____No medication of any type, whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Parent Signature: _____ Date: _____/_____/_____