



## 2020-2021 MEDICAL RELEASE FORM

Student's Name \_\_\_\_\_

It is understood that consent is given in advance of any emergency, diagnosis, or treatment required while the student is under the care of John Paul II Catholic High School, that this Medical Release Form authorizes designated school personnel to exercise their best judgement should action be warranted to ensure student's safety, life, and health. This form should be signed and will be kept with designated school personnel during the 2020-2021 school year.

In the space provided, describe what should be done in case of an emergency when religious beliefs prohibit any emergency medical attention for accident, sickness, or injury.

### General Information

Allergies to Food/Medication/Other \_\_\_\_\_

Specific Medical Problems \_\_\_\_\_

Other (please be specific) \_\_\_\_\_

### If any medication is currently being taken, provide the following information

Name of Medication(s) \_\_\_\_\_

Prescribing Physician \_\_\_\_\_

Physician's Office Phone Number \_\_\_\_\_

### Medical Information (will be used only in case of an emergency)

Insurance Company Name \_\_\_\_\_ Name of Insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

### Should there be an emergency, contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Employer \_\_\_\_\_

I hereby give permission for \_\_\_\_\_ to receive immediate medical treatment as required in the judgement of the attending physician. Notify me and/or person(s) listed above as soon as possible.

I do not give permission for medical treatment until I have been contacted.

Signed \_\_\_\_\_ Date \_\_\_\_\_

