

Information/Medical Authorization Form St. Mary School Information will only be shared with school personnel		Grade: _____ Room: _____ (Circle all that apply)	Student Picture Here (Office use only)
Student: _____		Transportation: Car or Car pool / Walker / Bus Rider	
Phone: (_____) _____		District: Elyria, Keystone, Midview am/pm	
Address: _____ City: _____		Extended Day: M T W TH F ALL	
		Car pools with: _____ ph: _____	
Father / Stepfather / Guardian Custody: Y / N		Mother / Stepfather / Guardian Custody: Y / N	
Name: _____		Name: _____	
Address: _____		Address: _____	
Home Phone: (_____) _____		Home Phone: (_____) _____	
Work Place: _____ City: _____		Work Place: _____ City: _____	
Work Phone: (_____) _____		Work Phone: (_____) _____	
Cell Phone: (_____) _____		Cell Phone: (_____) _____	
Other: _____		Other: _____	
Health Information: Please list any allergies, health concerns or medications. Specify type of reaction and emergency.			
Allergies: _____		Medications (reason for taking): _____	
_____		_____	
Consent for medical treatment in case of injury and unable to contact parent/guardian			
Doctor: _____		Dentist: _____	
Address: _____		Address: _____	
Phone: (_____) _____		Phone: (_____) _____	
Medical Specialist _____		Preferred Hospital: _____	
Address: _____		Address: _____	
Phone: (_____) _____ Hospital: _____		Phone: (_____) _____	
(Psychologist, Neurologist, Immunologist, Internist, etc.)		Insurance Carrier: _____	
Authorized pick up and consent for medical treatment in case of injury and unable to contact parent/guardian			
Name: _____		Phone: (_____) _____	
Name: _____		Phone: (_____) _____	
Name: _____		Phone: (_____) _____	
<p>In the event reasonable attempts to contact parent/guardian at one of these phone numbers: _____ or _____, I hereby give consent for the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or by Dr. _____ (preferred dentist), or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital or any other hospital reasonably accessible). This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists concurring the necessity for such surgery, are obtained before the surgery is performed.</p> <p>Custodial Parent or Legal Guardian must sign <input checked="" type="checkbox"/> _____ Date: _____</p>			
Refusal for Consent for medical treatment			
<p>I DO NOT give my consent for emergency medical treatment of my child. Therefore, I will not hold, St. Mary School, teachers, nurse, principal, or any employee or volunteer, St. Mary Church, or the Cleveland Catholic Diocese liable for not seeking medical treatment for my child.</p> <p>In case of illness or injury requiring emergency treatment, I wish the school authorities to take NO ACTION, or to:</p> <p>_____</p> <p>Custodial Parent or Legal Guardian must sign <input checked="" type="checkbox"/> _____ Date: _____</p>			

Please complete information on reverse side

Does your child have permission to go on field trips by way of walking, private vehicles, and/or bus with his/her class? Yes _____ No _____

Do you authorize the release of photographs to outside school publications such as local newspapers, television stations, etc., covering school activities, sporting events, and other articles? Yes _____ No _____

Signature of Parent/Guardian: _____ Date: _____