

Medical Information (Information is kept confidential. Confidential information is privy only to the DRE and Catechist).

Please specify any medical condition: for example – A.D.D., allergies, asthma.

Emergency Information

Alternate Emergency Name _____ Phone # _____ Cell# _____
Relationship _____

Doctor's Name _____ Phone # _____

Preferred Hospital _____ City _____

Medication Allergies _____
(If none, please indicate "none")

If you and the physician of your choice, as indicated above, cannot be reached in an emergency and, if in the judgment of the St. Maximilian Kolbe Religious Education Directors feel immediate medical and/or hospital attention is indicated, do you authorize these authorities to send your child (properly accompanied) to an available hospital or physician? Please check **Y** **N**

Signature of Parent/Guardian Date _____

As a parent and/ or guardian, I authorize the treatment of my minor child by a qualified and licensed medical doctor in the event of a medical emergency which in the opinion of the attending physician, may endanger his or her life, cause physical disability or undue discomfort if delayed. The consent is granted only after a reasonable effort has been made to reach me.

Signature of Parent/Guardian Date _____

I give permission to the following to pick up my child if I am unable to.

Name of person(s) picking up child Phone # _____

Signature of Parent/Guardian Date _____