

# SM SAINT MONICA PARISH

5136 N NOTTINGHAM AVE, CHICAGO, IL 60656 + (773) 763 - 1661 + WWW.STMONICACHICAGO.COM

*Please print legibly One Form per Student must be Completed*



STUDENTS NAME \_\_\_\_\_

## 2021-2022 STUDENT MEDICAL INFORMATION

### EMERGENCY CONTACT - *if parents cannot be reached*

Contact's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate #: \_\_\_\_\_

2<sup>ND</sup> Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate #: \_\_\_\_\_

### PHYSICIAN & MEDICAL INFORMATION

Physician Name: \_\_\_\_\_ Office Phone # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group/Member #: \_\_\_\_\_

Significant medical history: \_\_\_\_\_

Current Medications taken: \_\_\_\_\_

Allergies: \_\_\_\_\_

Special learning or developmental needs: \_\_\_\_\_

Additional information: \_\_\_\_\_

*In the event that the undersigned, or my authorized physician, cannot be reached, and in the judgement of the Director of Religious Education of St. Monica Parish, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my child, I hereby request and authorize any of the aforesaid responsibility for any personnel to obtain for my child such medical services as are deemed necessary. I agree to assume the financial responsibility for diagnosis/treatment and for medication deemed necessary. Release covers 08/01/20-07/31/2021.*

**I agree to the above agreement:**

\_\_\_\_\_  
*Signature of Parent or Legal Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Parent or Legal Guardian*

\_\_\_\_\_  
*Date*