SANTA MARIA DEL MAR
FAITH FORMATION
Pre-K thru 12th Grade
Parent/Guardian Medical Release Form
Diocese of St. Augustine
Date: **2021-22 School Year**

Child's Name:_____Date of Birth:_____

Parent/Guardian Name:_____

Home Address:_____

Home Phone:_____Cell Phone:_____

Name of Diocesan Entity:_____SANTA MARIA DEL MAR_____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child.

(Of the following statements pertaining to medical matters, sign only in accordance with your wishes.)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to the above names Diocesan entity's employees, volunteers or representatives to seek medical treatment for my child names above.

In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name and Relationship_____Phone_____

Family Doctor_____Phone_____

Family Health Plan Carrier_____Policy #_____

I make the following exceptions_____

Medication_____Dosage_____Doctor_____

Medical Problem or Condition (allergies,diabetes)_____

Condition_____Symptoms_____

Physical Disabilities_____

_____ _____

Signature of Parent/Guardian Date

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the above names Diocesan entity's volunteer or representative, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

_____ _____

Signature of Parent/Guardian Date