St. John Vianney
Medical Information and Release

This permission authorization is valid from _____ through _____ , inclusive.

Student Name _____ D.O.B. _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Mother's Name _____ Work/Cell Phone _____

Father's Name _____ Work/Cell Phone _____

Nearest Relative or Friend

_____ Home Phone _____ Work Phone _____

_____ Home Phone _____ Work Phone _____

Insurance Company _____

Policy Number _____

Contact Person (if applicable) _____

Medical Information

Allergies: _____

Medicine Allergies: _____

Food Allergies: _____

Date of last Tetnus shot: _____

Personal Medical Information: _____

Restrictions:

In the event that I cannot be reached in an emergency, I hereby give permission to the physician and/or hospital and it's medical staff selected by _____ to hospitalize, secure proper anesthesia, or to order injection or surgery for _____ .

Name of son/daughter

_____ _____

Signature of Parent Date

Notarized by: _____ on _____

Title: _____

My Appointment Expires: _____