Diocese of St. Augustine Parent / Guardian Medical Release

Child's Name:	Date of Birth:	
Parent / Guardian Name:		
Home Address:	Home Phone:	
of my child.	my knowledge, my child is in good health, and I assume all responsibility for the ng to medical matters, sign only in accordance with your wishes.)	ne health
EMERGENCY MEDICAL TREATMENT: In the event of a volunteers, or representatives to seek medical treatment for medical treatment for medical treatment.	an emergency, I hereby give permission to Diocese of St. Augustine's employed my child above named.	es,
	by give permission to the physician selected by the Diocesan representatives or order injection and / or anesthesia and / or surgery for my child above named.	
In the event of an emergency, if you are unable to reach me a	at the above number, contact:	
Name and Relationship:	Phone:	•
Family Doctor:	Phone:	
Family Health Plan Carrier:	Policy Number:	
My Child's Medications / Dosages:		
Medication:I	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 that my child becomes ill with symptoms such as headache, v medication to be administered to my child according to direct	to the attention of the Diocese of St. Augustine's employees, volunteers or representations, sore throat, fever, or diarrhea, I hereby give permission for over-the-citions.	sentatives counter
Signature of Parent / Guardian	Date	

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