Medical Authorization Form St. Joseph School

Please complete a form for each student

Student Name:_____ Grade:_____

DOB:_____

Parent/Guardian Name(s):_____

Parent/Guardian Phone #:_____

Student Medical History:

Allergies and reaction:_____

(seasonal, medication, food)

Medication (seasonal and daily):_____

Diseases, health conditions, physical impairments:_____

Other pertinent medical information:_____

In the event of a medical emergency, if parents/guardians/emergency contact are all unable to be reached, I would like my child taken to the following hospital:

_____

Student's Family doctor/pediatrician:_____

Phone:_____

_____ _____

Signature of Parent/Guardian Date