ST. MATTHEW SCHOOL
MEDICAL INFORMATION & EMERGENCY FORM
PLEASE PRINT ALL INFORMATION
ONE FORM PER STUDENT

Student (last, first, middle): _____

Address: _____

Student's Regular Physician: _____ Phone: _____

STUDENT MEDICAL CONDIDTIONS:

Please list any medical conditions (asthma, diabetes, epilepsy, etc.) _____

List any allergic reactions to medications: _____

List any medication the student is presently taking: _____

Other pertinent information: _____

Date of most recent tetanus shot: _____

MEDICAL INSURANCE INFORMATION:

Company _____

Plan Number _____ Plan Identification _____

EMERGENCY CONTACTS:

Parent or Guardian Name: _____

Daytime Phone: _____ Evening Phone_____

Other Contact Name:_____ Phone: _____

Relationship (friend, neighbor, etc.): _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of St. Matthew School. A copy will be distributed to the person in charge of each trip or athletic activity in which the student participates. Should the need arise this information will be given to the proper medical authorities.

I, _____, understand that in the case of illness or injury to my child, _____, the school will try to notify me or the person I have listed above as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to St. Matthew School to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

_____ _____
Signature of Parent/Guardian Date