

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT**

SCHOOL: Bridgeport Catholic Academy

SCHOOL YEAR: _____

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian _____ Parent/Guardian _____

Home Phone () _____ Work () _____ Home Phone () _____ Work () _____

Cell Phone () _____ Cell Phone () _____

Name of Student's Physician _____ Phone () _____

Address _____ City _____ State _____

Medical Insurance Provider _____ Policy/Insurance # _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME _____ RELATIONSHIP TO STUDENT _____

PHONE 1 () _____ PHONE 2 () _____

NAME _____ RELATIONSHIP TO STUDENT _____

PHONE 1 () _____ PHONE 2 () _____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforementioned personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY