SAINT MONICA PARISH
5136 N NOTTINGHAM AVE, CHICAGO, IL 60656 + (773) 763 – 1661 + WWW. STMONICACHICAGO.COM

STUDENT MEDICAL INFORMATION 2018-2019

OFFICE USE ONLY:

Last Name:_____ First Name:_____ Level:_____

EMERGANCY CONTACT – *if parents cannot be reached*

Contact's Name:_____ Relationship:_____

Phone: _____Alternate Number:_____

PHSICIAN & MEDICAL INFORMATION

Physician Name:_____ Office Name:_____

Address: _____ City:_____ZIP:_____

Insurance Company:_____ Group/Member No.:_____

Significant medical history:_____

Current Medications Taken:_____

Allergies:_____

Special learning or developmental needs:_____

Additional information:_____

_____

In the event that the undersigned, or my authorized physician, cannot be reached, and in the judgement of the Director of Religious Education of St. Monica Parish, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my child, I hereby request and authorize any of the aforesaid responsibility for any personnel to obtain for my child such medical services as are deemed necessary. I agree to assume the financial responsibility for diagnosis/treatment and for medication deemed necessary. Release covers 08/1/2018–06/15/2019.

I agree to the above agreement:

_____ _____

Signature of Parent or Legal Guardian *Date*

_____ _____

Signature of Parent or Legal Guardian *Date*