

MEDICAL RELEASE / EMERGENCY INFORMATION

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT/Paramedic, E.R. Physician).

In any event, I/we agree to hold St. Joan of Arc Parish harmless for any actions performed by their staff in assisting my/our child(ren), arising from a medical emergency.

Family Physician: _____ Phone:()_____

Hospital Preference: _____

Whom should we contact in case of emergency, if we cannot reach you?

Name: _____ Relationship to Child: _____

Home Phone: ()_____ Cell Phone: ()_____

MEDICAL CONDITIONS / MEDICATIONS

Please list any allergies/medical problems, behavioral issues, including those requiring maintenance medications (i.e. Diabetic, Asthma, ADD, ADHD, Autism, Dyslexia, Seizure Disorder, Allergies, etc.).

Allergies / Medical Diagnosis / Behavioral Conditions	Medications Being Taken

Does child have any learning disability? _____

OTHER THAN PARENTS, THE FOLLOWING PERSONS ARE AUTHORIZED TO PICK UP CHILD

The following persons are authorized to pick up and sign out my child from the Religious Ed classroom or office:

First and Last Name	Phone Number	Relationship to Child

Signature and Date: _____ / / _____ / /
Father/Guardian
Mother/Guardian

TIME AND TALENT COMMITMENT

Keeping with program expectations, our family is willing and able to volunteer in the following areas:

TEACH _____ ASSIST _____ DAY: SUNDAY _____ WEDNESDAY _____ TUESDAY _____
HALL MONITOR: SUNDAY _____ WEDNESDAY _____ OFFICE (Day/Time): _____

Provide scholarship toward financial assistance for a family in need _____