

**UNIVERSAL MEDICAL INFORMATION/ EMERGENCY CONTACT
RELEASE AND CONSENT FORM**

SCHOOL NAME: ST. FINN BARR SCHOOL	SCHOOL YEAR: 2019-2020	GRADE:
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Student Information:

LAST NAME	
FIRST NAME	
MIDDLE NAME	
BIRTHDATE	
ADDRESS	
CITY, STATE, ZIP	
HOME NUMBER	

Siblings at school:

NAME	GRADE

Student lives with (check all that apply):

<input type="checkbox"/>	MOTHER
<input type="checkbox"/>	FATHER
<input type="checkbox"/>	GUARDIAN (S) (SPECIFY):

____ Father's ____ Legal Guardian's Information:

FIRST NAME	LAST NAME

Work Address:

STREET	CITY	STATE	ZIP

Home Address (If Different from child's):

STREET	CITY	STATE	ZIP

NUMBERS:

WORK PHONE	
HOME PHONE	
CELL PHONE	
E-MAIL ADDRESS	

____ Mother's ____ Joint Legal Guardian's Information:

FIRST NAME	LAST NAME

Work Address:

STREET	CITY	STATE	ZIP

Home Address (If Different from child's):

STREET	CITY	STATE	ZIP

CONTACT NUMBERS:

WORK PHONE	
HOME PHONE	
CELL PHONE	
E-MAIL ADDRESS	

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Emergency Contacts:

NAME	TELEPHONE NUMBER	RELATIONSHIP TO STUDENT

Student Medical Information:

Primary Physician Information:

NAME:	
ADDRESS:	
TELEPHONE:	

Emergency Physician:

NAME:	
ADDRESS:	
TELEPHONE:	

Medical Conditions: (e.g. diabetes, epilepsy, heart conditions, etc.)

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Disabilities:

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Allergies: (e.g. hay fever, strawberries, peanuts, etc.)

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Medications:

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Allergies to Medications:

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Medicines to be Self- Administered by the Child: (See Below):

Dosage:		Frequency:	
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Medicines to be administered by the School (IF parents/guardians and school both agree that school shall do so; see below):

Dosage:		Frequency:	
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DATE:	
SIGNATURE:	
RELATIONSHIP TO CHILD:	