UNIVERSAL MEDICAL INFORMATION/ EMERGENCY CONTACT
RELEASE AND CONSENT FORM

SCHOOL NAME: ST. FINN BARR SCHOOL	SCHOOL YEAR: 2018-2019	GRADE:

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):

☐	MOTHER
☐	FATHER
☐	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.)

Disabilities:

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

Medications:

Allergies to Medications:

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

Dosage:	**Frequency:**

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

Dosage:	**Frequency:**

DATE:	
SIGNATURE:	
RELATIONSHIP TO CHILD:	