MEDICAL INFORMATION

Student's Primary Physician	**Office Phone** **(000-000-0000)**
Diagnosed Health Issues or Limitations:	
Student may have over the counter Medications dispensed at School (Ibuprofen, Acetaminophen, Aspirin, etc.) (Please circle) Yes or No **X**_____ *Custodial Parent/Guardian* ***Signature***	**_____I am sending a list of special instruction regarding medications for my son.**

Emergency Contacts

Please list 3 contacts – Parent/Guardian 1st (please print)

1st - Last Name, First Name	**Parent/Guardian**	**Cell Phone**	**Work Phone**	**Other**
2nd - Last Name, First Name	**Parent/Guardian**	**Cell Phone**	**Work Phone**	**Other**
3rd - Last Name, First Name	**Other**	**Cell Phone**	**Work Phone**	**Other**

In case of accident or serious illness, I request that St. Mary's High School contact me. If the school is unable to reach me, I hereby authorize St. Mary's to call the physician listed in the Student Information Section of this form and to follow his/her instructions. If it is impossible to contact this physician, St. Mary's may take whatever measures necessary to ensure the safety of my son.

Parent/Guardian Signature: _____Date: _____

***** If you wish to include additional information please print it on the back of this form. Thank you! *****