



ANNUAL MEDICAL RELEASE FORM

St. Bede Catholic Church, P.O. Box 5400, Williamsburg 23188, 757-229-3631

PARISH/SCHOOL _____

PARTICIPANT'S NAME _____

Sex _____ Date of Birth _____ Soc.Sec.# _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work (_____) _____

NAME OF PARENT/GUARDIAN _____

Insurance Company: _____

Policy Holder's Name: _____

Relationship to Policy Holder: _____

Policy Number: _____

In case of an emergency notify: _____

Home No. (_____) _____ Work No. (_____) _____

Medical Information

1) Does your child have any allergies? _____ YES _____ NO
If "YES", please list

2) Does your child have medication of any type, with them?
If "YES", please list.

3) Is there any other physical or emotional condition of which we need to be aware? Please explain.

In the event of any emergency, I give authority to the accompanying adults to authorize treatment. I understand that an attempt to notify me will be made before any treatment is authorized.

PARENT/GUARDIAN SIGNATURE:

_____ Date _____