

ST. GABRIEL HIGH SCHOOL YOUTH GROUP (BOK) - MEDICAL RELEASE FORM

Student's Name _____ Age _____ Student's cell phone # _____

Mom's Name(s): _____ Dad's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Family Physician Name _____ Phone _____

Family Dentist _____ Phone _____

Telephone Numbers for Parent or Guardian, in the event of an Emergency:

Home phone #: _____

Mom's work phone #: _____ Mom's cell phone #: _____

Dad's work phone #: _____ Dad's cell phone #: _____

Health insurance carrier _____ Name of policyholder _____

Policy/Member number _____ Group number _____

In the event of injury or illness, I (we), the parent (s) or legal guardians (s) of this participant, hereby grant our permission for said participant to be taken to a doctor or hospital and hereby authorize medical treatment, including, but not limited to emergency surgery or medical treatment, and assume the responsibility of all medical bills. I give permission for the release of medical records to an attending physician in case of illness. I agree not to hold St. Gabriel Parish, its staff, chaperones or volunteers liable for any medical bills or injuries that my child may incur. St. Gabriel does not provide health insurance coverage for children and it is presumed that parents have insurance.

Signature of Parent/Legal Guardian: _____ Date: _____

The following includes any medical problems you may have (ie), asthma, allergies, including food allergies, or food preferences, hearing difficulties, back troubles, seizures, or any other facts to which the staff, a physician or dentist should be alerted:

Any recent major illnesses:

Presently on any medication? Yes ___ No ___ If "Yes" please list all medications needed and times of intake:

Date of last tetanus shot _____

Any and all information concerning the above named child's history including allergies, medications and physical impairments, has been reported in this registration form. In the event of an emergency, I authorize St. Gabriel to share the completed registration information packet with persons related to the treatment of the above named program member. I agree to all of the above statements, and that they are accurate and true.

Parents/Guardians Signature

Date