



Saint Bernard School MEDICAL RELEASE FORM

As the parent/legal guardian of:

Name of Student:	
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I request that in my absence the above-named student be admitted to any hospital or medical facility for diagnosis and treatment. I give permission for a representative of Saint Bernard School to act on my behalf. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named student.

Date of student's birth:		Date of last Tetanus Booster:	
Known allergies of this student, including any allergies to medicine:			
Any other medical problems which should be noted:			

Family Physician:	Phone: ()
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Parent/Guardian:			
Street Address:			
City:	State:	Zip:	
Phone # H: ()	Work #: ()		

Person responsible for charges: <small>(if different from above)</small>			
Street Address:			
City:	State:	Zip:	
Phone # H: ()	Work #: ()		

Person to notify if parent/guardian is unavailable:			
Street Address:			
City:	State:	Zip:	
Phone # H: ()	Work #: ()		

Insurance Carrier:	Policy Number:
Name of Insured:	Phone: ()

Name of Parent /Guardian: _____ **Date:** _____

Signature of Parent /Guardian: _____