Mater Christi Church
2431 E. 10th Avenue
North Riverside, IL 60546

**Medical Information**
**Authorization for Medical Treatment**

**Medical/Emergency Information**

| Name | Grade Level | Last tetanus immunization |
|---|---|---|
| | | |

**Medical allergies/medications/significant medical history:**

_____
_____
_____
_____

Mother's Name _____ Home#_____ Cell# _____
Father's Name _____ Home#_____ Cell# _____

Name of Physician _____ Phone# _____
Medical Insurance Company _____
Insurance Number _____

**Other Contact in case of emergency**:
Name: _____ Phone _____
Relationship _____

**Medical Release**

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of the Coordinator of Religious Education, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child, I (we) hereby request and authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary. This release is intended for the duration of the CCD session September 2017-April 2018.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

**Email Contact:**
Email communication often seems to be the most convenient for catechists to communicate to parents or for quickly sharing information about a cancelled session, due to weather, etc. Please include below an email address for such contact with your signature of consent to use this address for communication as you prefer.

Email Address: _____
_____I consent to the use of my address for any professional communication regarding Faith Formation.
_____I consent to the use of my address for emergency use only (cancelled session, etc.).
_____I do not want any email contact at all.

Signature _____ Date _____