

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 2014-April 2015.

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 _____