

**APPENDIX A**

**ANNUAL MEDICAL RELEASE FORM**

**PARISH/SCHOOL** \_\_\_\_\_

**PARTICIPANT'S NAME** \_\_\_\_\_

**Sex** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**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** \_\_\_\_\_