

**SANCTA FAMILIA ACADAEMY**  
**Medical Release Form 2008-2009**

(MUST ACCOMPANY STUDENT TO HOSPITAL)

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Date of last Tetanus booster: \_\_\_\_\_

Are there any medical or health related problems? \_\_\_ Yes \_\_\_ No

If yes, what are they and are there any restrictions? \_\_\_\_\_

Are there any food allergies? \_\_\_ Yes \_\_\_ No

If yes, what are they and are there any restrictions? \_\_\_\_\_

I \_\_\_\_\_ do / \_\_\_\_\_ do not give Sancta Familia staff members / volunteers permission to administer TYLENOL to my child if the need arises. Dosage? \_\_\_\_\_

In the case of emergency, I hereby grant permission for Sancta Familia Academy Staff to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

1. Attempt to contact parent or guardian
2. Attempt to contact parent or guardian through any of the persons listed on this form
3. Call 911

Any expenses incurred will be the responsibility of the child's family. Sancta Familia Academy or its employees will not be responsible for false medical or personal information given at time of enrollment.

Name of Parent(s) \_\_\_\_\_ Home Telephone Number \_\_\_\_\_

Mother's Work Number \_\_\_\_\_ Father's Work Number \_\_\_\_\_

Mother's employer/occupation \_\_\_\_\_ Father's employer/occupation \_\_\_\_\_

Mother's Cell Number \_\_\_\_\_ Father's Cell Number \_\_\_\_\_

Name of a LOCAL Emergency Contact (if parents cannot be reached) \_\_\_\_\_

Relationship to student \_\_\_\_\_ Telephone Number \_\_\_\_\_

I (we) the undersigned parent(s) or guardian(s) of the minor child named above, do hereby authorize and consent to any x-ray, examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or specific supervision of any member of the medical staff and/or the emergency room staff licensed under the provisions of the Medical Practice Act and/or the staff of any acute general hospital or emergency clinic holding a current license to operate a hospital or emergency clinic, from the state of Florida, Department of Health Services. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority to render care which the aforementioned physician, in the exercise of his/her best judgement, may deem advisable. It is understood that every effort shall be made to contact the undersigned parent(s) or guardian(s) prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. The undersigned also assumes the responsibility for any and all costs associated or connected with such treatment and hereby releases all leaders, associates, members, or others acting for or on behalf of SANCTA FAMILIA ACADEMY from any and all liability and agrees to hold harmless all of the above.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under any emergency circumstances in my absence, and shall be valid until revoked in writing.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Father/Guardian Signature

\_\_\_\_\_  
Mother/Guardian Signature

# 2008-2009 Emergency Medical Information

Persons permitted to pick up student:

Name	Phone Number	Address	Driver's License No.

Physician(s) to contact in the event of an emergency:

Name	Phone Number	Address

Dentist(s) to contact in the event of an emergency:

Name	Phone Number	Address

Insurance Primary Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Secondary Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Has there been a recent exposure to a contagious disease:  Yes  No If yes, what and when?

\_\_\_\_\_

Any history of medical problems we need to be aware of?  Yes  No If yes, what and when?

\_\_\_\_\_

\_\_\_\_\_

Are there any allergies or reactions to medications, insect bites, etc.?  Yes  No If yes, what?

\_\_\_\_\_

List present medications: \_\_\_\_\_

**All medications, prescription or over-the-counter, must be brought to the office and a "Request to Administer Medication" must be completed by the parent/guardian.**