

Student's Name _____

Grade _____ (in 2011 – 2012)

Birthdate: _____

Home Phone: _____

MEDICAL RELEASE FORM

Father's Name Employer Telephone & Ext. Beeper/Pager/Cell

Mother's Name Employer Telephone & Ext. Beeper/Pager/Cell

In case of an emergency, list person(s) to contact if the person legally responsible cannot be reached:

Name Relationship Home Telephone Cell or Pager Authorized to Pick Up

Name Relationship Home Telephone Cell or Pager Authorized to Pick Up

Physician's Name _____ Office Phone _____

Address of Practice _____

Dentist's Name _____ Office Phone _____

Address of Practice _____

Preferred Hospital _____ Phone _____

I give my permission and approval for the above named student to participate in any athletic team, group or associated activities or field trips supervised by the staff of Covenant Academy.

I hereby authorize the staff of Covenant to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care for my child. Any qualified physician called by Covenant may treat and do whatever is necessary for the health and well-being of my child.

I also agree to accept responsibility for the cost of above medical services.

I assume all risks and hazards incidental to such participation, including transportation to and from activities, and I do hereby waive, release, absolve, indemnify and agree to hold harmless the local Inter-Parochial League, school, organizer, sponsors, supervisors, participants and persons transporting my child, whether the result of negligence or any other cause, except to the extent and amount covered by accident or liability insurance.

For hospital information, this child is covered by medical insurance: _____
Insurance Company Policy #

My child is allergic to: _____
(including peanuts, bee stings, drugs, other foods and/or stimulants)

Has student been diagnosed with any of the following conditions?	YES *	NO
Diabetes		
Anemia		
Asthma		
Seizures/Epilepsy		
Other special medical conditions, physical limitations, or previous surgeries?		

If you answered YES to any of the above questions, please provide details; (i.e. treatment, inhalers, medications, etc.)

Parent/Guardian Signature _____

Date _____