



MEDICAL RELEASE FORM
American Martyrs Catholic Church
624 15th Street, Manhattan Beach, CA 90266
(310) 545-5651 or (310) 546-4734

PLEASE PRINT ALL INFORMATION:

Name of Minor: _____
First Name M.I. Last Name

Home Telephone #: (____) _____ Date of Birth: ____/____/____

Mother's Name: _____ Work Tel.#: (____) _____

Father's Name: _____ Work Tel.#: (____) _____

Home Address: _____
Street Number & Name Apt. #

City Zip Code

Emergency Information:

Emergency Contact: _____ Relationship: _____

Home Tel. #: (____) _____ Work Tel. #: (____) _____

Health History & Insurance Information:

Please list any pre-existing or present medical condition that we need to be aware of:

Please list any medication(s) and the dosage of the medication(s) that your son/daughter is taking, along with any instructions for the administration of medication if applicable:

Please list any allergies (medication, food, other) that your son/daughter has:

Please list any physical restrictions that your son/daughter has (i.e.: swimming, running, etc.):

Please list any additional information you feel is important for us to know regarding the health of your child (including any special dietary needs.):

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while the minor is in attendance at these activities.

Do you have health insurance? _____NO _____YES

Name of Company: _____

Policy #: _____ Group #: _____

In whose name is the insurance policy under? _____

Name of family doctor: _____ Tel. #: (____) _____

PERMISSION TO TREAT IN CASE OF AN ACCIDENT/EMERGENCY:

I, the legal guardian of the above named minor, request that he/she be permitted to participate in the field trip(s) sponsored by American Martyrs Youth Ministry. I agree to direct the minor to cooperate and conform with the directions and instructions of parish or archdiocesan personnel responsible for the field trip/event. I agree that in the event the minor is injured as a result of his/her participation in the field trip/event, including transportation to and from these activities whether or not cause by the negligence (active or passive) of the parish or archdiocesan youth activity program, or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident hospital or medical insurance, or any available benefit plan of mine or of my spouse. I am not aware of any medical condition of my child which would render the event(s) inappropriate for him/her to participate in. I hereby give permission to the physician selected by the youth activities supervisory personnel then present, to render medical treatment deemed necessary and appropriate by the physician.

Parent/Legal Guardian Signature

Date

Please PRINT name of the above signature.