Medical Form—Faith Formation

LaPorte Catholic Church

Sacred Heart/Saint Joseph/Saint Peter

Student's Name: _____ Date of Birth (MM/DD/YY): _____

Address: _____ City: _____ ZIP: _____

Mother's Name: _____ Best Phone Number: _____

Father's Name: _____ Best Phone Number: _____

Other Guardian: _____ Best Phone Number: _____

In case of divorce/separation, child lives with _____

Family Doctor's Name: _____ Phone: _____

Insurance Name: _____ Policy Number: _____

Hospital Preference: LaPorte ____ Franciscan ____ Other _____

Allergies or Medical Needs: _____

_____

Date of Last Tetanus Vaccination: _____ Immunization up to date? Yes___ No____

Please list the names and phone numbers of three responsible persons we can contact if you are unreachable in an emergency.

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Authorization for Treatment of a Minor

I, _____, the parent or legal guardian of _____, give my consent for emergency medical and surgical treatment of this minor in a licensed hospital by a licensed Indiana physician should his/her conditions so require it in my absence. I understand that in such case reasonable attempts would be made to first contact me, time and conditions permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitation or prohibitions regarding treatment unless indicated below. I assume financial responsibility for the same.

Limitations/Prohibitions: _____

Signed: _____ Print: _____

Date: _____

Updated July 2020