Catholic Archdiocese of Atlanta
St. Joseph Catholic School
Child Release for Medical treatment

In case of Emergency and in the event that my child is not coherent or conscious, I hereby grant _____ and/or other adult persons of St. Joseph Catholic School permission to act on my child's behalf in seeking emergency medical treatment, in the event that such treatment is deemed necessary.

I hereby give my permission to those administering medical treatment to do so.

I further absolve and release St. Joseph Catholic School, its Pastor, employees, and volunteers, as well as the Archdiocese of Atlanta and its employees; from any liability whatsoever when acting on my child's behalf in regard to medical treatment, and in any other respect deemed necessary should my child become incapacitated.

Name of Participant:_____

Address:_____City:_____State:____Zip:____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Health Insurance Company: _____

Policy Number:_____

Insurance Company Address/Phone:_____

Additional comments regarding medical history, allergies, medications, or other conditions:_____
_____
_____

In the event of an emergency, please contact the person(s) named below:

Name:_____
Relationship:_____
Phone Number(s):_____

Signature of Parent/Guardian:_____

Date: _____