CHRIST THE KING STUDENT MEDICAL INFORMATION CARD

STUDENT NAME: (print) _____ **DOB:** _____

ADDRESS: _____ City: _____ Zip: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____ CELL PHONE: _____

INSURANCE CARRIER: _____ POLICY # _____

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

PHYSICIANS

PRIMARY: _____ PHONE #: _____

SECONDARY: _____ PHONE #: _____

MEDICAL HISTORY/CONDITIONS: (If more space is needed use back of paper)

MEDICATIONS: _____

ALLERGIES: _____

CONSENT FOR MEDICAL TREATMENT:

In the event of an accident, emergency, or sudden illness to my child, I hereby authorize a representative of Christ the King School to seek medical attention and treatment for my child: _____.

I further agree to fully indemnify Christ the King School, and the individuals rendering the same, against any claims which may arise there from.

PARENT'S SIGNATURE: _____ **DATE:** _____