

Church of Saint Matthew Faith Formation Emergency Contact and Medical Information

1st Child's Full Name: _____ Date of Birth: ____/____/____ M F

Allergies/Special Needs: medical, learning, physical? _____

2nd Child's Full Name: _____ Date of Birth: ____/____/____ M F

Allergies/Special Needs: medical, learning, physical? _____

3rd Child's Full Name: _____ Date of Birth: ____/____/____ M F

Allergies/Special Needs: medical, learning, physical? _____

4th Child's Full Name: _____ Date of Birth: ____/____/____ M F

Allergies/Special Needs: medical, learning, physical? _____

Parent/Guardian Information

Mother's name/Guardian's Name

Father's name/Guardian's Name

() _____

() _____

() _____

() _____

Home Phone

Work or cell #

Home Phone

Work or cell #

Address

Address

City, ST ZIP Code

City, ST ZIP Code

Emergency Contacts

In case of emergency, who should we call first? _____ Mother or _____ Father

If we cannot reach either mother or father, who would be your **other emergency** contact?

Name: _____

Home Phone # () _____ Work or Cell#: () _____

Address: _____

Relationship to child/children? _____

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian, nor designated emergency contact, can be reached in the case of an emergency.

Parent's/Guardian's Signature

Date