

St. Isaac Jogues Roman Catholic Church

Religious Education & Youth Faith Formation Office

427 S Clay St
Hinsdale, IL 60521
630-323-0265 (phone)
630-655-5539 (fax)
re@sjhinsdale.com (email)

MEDICAL PERMISSION FORM:

I grant permission for the administration of First Aid by the people in charge of St Isaac Jogues Religious Education Programs, and those transporting my child to and from the event as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I understand I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, I understand that every effort will be made to contact the parent/guardian of the participant. In the event that I cannot be reached, I hereby give permission to the physicians selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary for my child.

INSURANCE INFORMATION:

Policy in the name of _____

Insurance Company _____

Policy Number: _____

Identification Number and/or Social Security Number: _____

Authorized Physician _____ Phone _____

CHILD/CHILDREN INFORMATION (PLEASE PRINT):

Child # 1 Name _____ Birth Date _____ Grade _____

Allergies to medication or other? YES _____ NO _____

If yes, please describe:

Please describe any and all educational/social or family situations that will help us to work effectively with your child.

OVER

Child # 2 Name _____ Birth Date _____ Grade _____

Allergies to medication or other? YES _____ NO _____

If yes, please describe:

Child # 2 continued

Please describe any and all educational/social or family situations that will help us to work effectively with your child.

Child # 3 Name _____ Birth Date _____ Grade _____

Allergies to medication or other? YES _____ NO _____

If yes, please describe:

Please describe any and all educational/social or family situations that will help us to work effectively with your child.

Child # 4 Name _____ Birth Date _____ Grade _____

Allergies to medication or other? YES _____ NO _____

If yes, please describe:

Please describe any and all educational/social or family situations that will help us to work effectively with your child.

Signature of Parent/Guardian: _____ Date _____

Address: _____
Street city state zip

Primary Phone _____ Secondary Phone _____

In Case of Emergency, contact _____

Phone #'s _____