DIVINE WORD\ST NOEL YOUTH MINISTRY
MEDICAL INFORMATION

Student' Name ______________________________

Address ______________________________

Telephone ______________________________

Do you have medical coverage? Yes ______ No ______

If yes, give:

Name of Plan ______________________________

Plan Number ______________________________

Preferred hospital which accepts your insurance:

Local ______________________ Greater Cleveland ______________________

Student's Physician ______________________ Phone: ______________

Student's Dentist ______________________ Phone: ______________

Medication student is taking ______________________________

Medication to which student is allergic ______________________________

Other allergies or medical problems ______________________________

For Emergency Purposes: Father's place of employment ______________

Telephone ______________

Mother's place of employment ______________

Telephone ______________

If someone other than parents have custody, specify who person is, relationship, address and phone number

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In the event reasonable attempts to contact me at ______________________ (phone) or ______________________ (other parent) at ______________________ (phone) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. ______________________ (preferred physician) or Dr. ______________________ (preferred dentist), or in the event the designated preferred Practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to ______________________________ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for surgery, are obtained before surgery is performed.

I understand this form and know that if I have questions I can call 256-1412.

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(parent or guardian signature)

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(date)

7/97