St. Joseph Catholic Church

228 East Hendricks Street, Shelbyville, IN 46176
Phone (317) 398-8227

Medical Permission

I grant permission for the administration of First Aid to _____ by the People in charge of the event, and those transporting me to and from the program as their judgment deems advisable. I also grant permission that any/all necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. My Emergency Contact 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 Emergency Contact of the participant. In the event that they 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 myself.

Please Print Name _____ Date of Birth_____

Allergic to Medication? No___ Yes____ If Yes, what _____

Other Allergies (insect bites, food allergies, etc.)_____

Medications(s) presently taking _____
_____

IN CASE OF EMERGENCY CONTACT

Emergency Contact Printed_____ Address: _____

Day Phone #_____ Evening Phone #_____ Cell _____

Contact Person if unable to reach cannot reach person named above: _____

Relationship _____ Phone #(s) Home: _____ Cell: _____

Insurance Information

Policy in the name of _____for_____

Insurance Company_____

Identification Number and/or Social Security Number_____

Authorized Physician _____ Phone #_____

Signature: _____Date_____