ST. JOSEPH SCHOOL

1810 HOWARD DRIVE KNOXVILLE, TN 37918

PHONE (865) 689-3424 FAX (865) 687-7885

STUDENT MEDICAL RELEASE FORM

STUDENT NAME (PRINT)_____

GRADE _____ BIRTH DATE _____ SOCIAL SECURITY #_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

HOME PHONE # _____ PARENT/GUARDIAN CELL PHONE # _____

EMERGENCY CONTACT INFORMATION:

FATHER'S NAME	MOTHER'S NAME	1ST NON PARENTAL CONTACT NAME	2ND NON PARENTAL CONTACT NAME
EMPLOYER	EMPLOYER	RELATIONSHIP	RELATIONSHIP
WORK PHONE #	WORK PHONE #	DAYTIME PHONE #	DAYTIME PHONE #
CELL PHONE#	CELL PHONE #	CELL PHONE #	CELL PHONE #

DOCTOR	DENTIST	INSURANCE
NAME	NAME	INSURANCE COMPANY
ADDRESS	ADDRESS	POLICY #
PHONE #	PHONE #	HOSPITAL
HOSPITAL – 1ST PREFERENCE	HOSPITAL – 2ND PREFERENCE	HOSPITAL – 3RD PREFERENCE

(PLEASE COMPLETE FORM ON THE BACK)

PRESCRIPTION MEDICATION(S) MY CHILD IS TAKING REGULARLY:

1) _____	3) _____	5) _____
2) _____	4) _____	6) _____

PICK-UP AUTHORIZATION

Please list the name(s) and phone number(s) of EVERY PERSON who is authorized to pickup this child from school and after school care. The student will not be released to anyone not on the list. Please indicate the order in which these people should be contacted.

1. **Name: _____ Phone number(s) _____**
2. **Name: _____ Phone number(s) _____**
3. **Name: _____ Phone number(s) _____**
4. **Name: _____ Phone number(s) _____**
5. **Name: _____ Phone number(s) _____**

ENTER "X" IF ANY OF THE FOLLOWING APPLY TO YOUR CHILD'S HEALTH HISTORY:

__ ADHD (Attn. Deficit Hyperactive Dis.)	__ Diabetes	__ Poor Vision	__ Tuberculosis
__Asthma/Wheezing	__ Hearing Problems	__ Reaction to Medication	__ Tubes in ear(s)
__ Bladder Infection	__ Heart Monitor	__Speech Therapy	__ Worms
__Cardiac History	__ Heart Murmur	__ Stuttering	__ Other (Please specify below)
__ Convulsions/Seizures	__ Hemophilia	__ Tonsillitis	

Describe treatment for the above checked item(s):

_____

_____

Allergies (food, insect, medicines)

_____

_____

_____

Special Conditions:

_____

_____

_____

MEDICAL RELEASE

This is to certify that I voluntarily furnished medical and insurance information to Saint Joseph School. I hereby request that in the event that I, or the people designated for an emergency cannot be reached in a timely manner, that an official representative of SJS seek and approve first aid or emergency medical care at the nearest, most adequate facility available.

SIGNATURE **PRINT NAME** **DATE**