Saint Therese Classical Academy and Learning Center
Medical Release Form

STUDENT NAME: _____ Birth date: _____
Street Address_____
City, State, Zip_____
Home Phone ( )_____ Social Security Number _____

FATHER'S NAME: _____ Home Phone: ( )_____
Employer (Name and Address): _____
Work Phone: ( ) _____ Cell Phone: ( )_____
E-Mail Address: _____

MOTHER'S NAME:_____ Home Phone: ( )_____
Employer (Name and Address): _____
Work Phone: ( ) _____ Cell Phone: ( )_____
E-Mail Address: _____Beeper: ( )_____

ADDITIONAL EMERGENCY CONTACTS
Name: _____ Name: _____
Relationship: _____ Relationship: _____
Phone: ( )_____ Phone: ( )_____

HEALTH INSURANCE COVERAGE
Insurance Company Name: _____
Insurance Company Phone Number: _____
Cardholder's Name_____ Employer: _____
Group Number _____ Individual I.D. _____
PHYSICIAN: _____
Address _____ Phone: ( )_____
DENTIST: _____
Address _____ Phone: ( )_____
PREFERRED HOSPITAL: _____
Address _____ Phone: ( )_____

ADDITIONAL INFORMATION
Allergies to food/medicine: _____
_____
Additional medical conditions (including the wearing of eyeglasses or hearing aides):
_____
_____

I hereby give permission to the director and teachers of the Saint Therese Classical Learning Center, Inc. to arrange for my child to receive medical attention in the event of an emergency. I recognize that every effort will be made to contact me and/or the emergency contact person(s) named above.

PARENT(S) SIGNATURE_____ DATE