COMMUNAUTE CATHOLIQUE FRANCOPHONE DE CHICAGO

MEDICAL FORM

SAINT TERESA OF AVILA

www.ccf-chicago.org

Medical Information Form YEAR 20 - - / 20 - -

Children's Full Names: ____

Family Doctor's Name: ______________________________ Phone: ________________

Doctor's Address: ____

Insurance Company: _______________________________ Policy No: _______________
Insured name: _____________________________________
Social security number: _____________________________
(Please join a copy of your insurance card)

I hereby give my permission for my
chil(ren)____ to
participate in the "**C**ommunaute **C**atholique **F**rancophone de **C**hicago" Religious Education program. I hereby release and indemnify Ste Teresa of Avila Parish, it's staff, the French staff and the catholic bishop of Chicago, a corporation sole, from any and all liability arising from claims of any kind of nature whatsoever from my child's participation in this program.

Date________________ Parent signature__________________________________

Authorization for Emergency Treatment

I, ___________________________________, give permission to the adult responsible, to secure medical treatment for my child / children named above, in an emergency situation.

________________________________ _________________________ ___________
Signature Relationship Date

Allergies to medications, foods, and insect bites:

____

Chronic Conditions (for example – Asthma, diabetes, etc.):

____

Comments or concerns (If your child has any learning disabilities, or vision or hearing problems that we should be aware of, please indicate that here):

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