

**ST. JOSEPH PROGRAMS
MEDICAL INFORMATION FORM**

Name of Member _____

Phone - Home _____ Cell _____

Name of person & phone number of person to contact if parent cannot be reached:

_____ Phone _____

_____ Phone _____

MEDICAL INFORMATION

My child is allergic to the following foods or medication: _____

My child has a medical condition that you should be aware of: _____

Name of Physician _____ Phone _____

My child presently takes this medication: _____

You have my permission to give my child the following medication if necessary:

Medication _____ Dose _____

MEDICAL RELEASE

If I or my emergency contact person cannot be reached, please seek medical treatment for my child in an emergency.

Parent's signature

Date