

**St. Thomas Aquinas School
Emergency Medical Card (one per student)**

Grade: _____ Room: _____

Name _____

D.O.B. _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Email _____

Pager # _____

Father's Name _____

Father's Cell _____

Employer _____

Work # _____

Mother's Name _____

Mother's Cell _____

Employer _____

Work# _____

Emergency Numbers (name & phone numbers of local person(s) to be notified when parent is not available). The student may also be released to the people listed below.

1) _____

2) _____

3) _____

Medical Treatment Release Form

Family Physician _____ Phone _____

Physician Address _____ City _____

List allergies, medication, contact lens or other pertinent comments:

Health Insurance Data

Group _____

Company _____

Contract _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under **emergency circumstances** in my absence.

Signed _____

Date _____