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_____