

	Last Name
Student(s) First Name(s)	Grade
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH INFORMATION *which PSR personnel should know about, including any medical information, allergies, and wishes for handling any physical/medical emergency.*

In case of an accident or serious illness, I request Parish School of Religion personnel to contact me. If the personnel are unable to reach me, I hereby authorize Parish School of Religion personnel to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, Parish School of Religion personnel may follow my instructions above or make whatever arrangements seem necessary.

Signature of Parent or Guardian: _____ **Date:** _____

Local Physician: _____

Address: _____

Phone Number(s): _____

Emergency Center/Hospital: _____

Phone Number(s): _____