

**UNIVERSAL MEDICAL INFORMATION/ EMERGENCY CONTACT  
RELEASE AND CONSENT FORM**

**School: ST. DUNSTAN CATHOLIC SCHOOL, Millbrae, CA 94030 School Year: 2018-2019**

Name of Student (Last, First, Middle) \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher Name: \_\_\_\_\_

Student Address:

Street \_\_\_\_\_ Apartment \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_

**Siblings at school:**

Name	Grade	Teacher
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Name	Grade	Teacher
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**Student lives with (check all that apply):**

Mother

Father

Guardian(s) (specify): \_\_\_\_\_

**\_\_\_\_ Father's \_\_\_\_ Legal Guardian's Information:**

Name (Last, First) \_\_\_\_\_

Work Address:

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Address (If Different from child's):

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (If Different from child's): (\_\_\_\_) \_\_\_\_\_

Work Telephone: (\_\_\_\_) \_\_\_\_\_ Mobile phone: (\_\_\_\_) \_\_\_\_\_

**\_\_\_\_ Mother's \_\_\_\_ Joint Legal Guardian's Information:**

Name (Last, First) \_\_\_\_\_

Work Address:

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Address (if different from child's):

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (if different from child's): (\_\_\_\_) \_\_\_\_\_

Work Telephone: (\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_

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**Emergency Contacts:**  
Name and Address

Telephone Number(s)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Student Medical Information:**

Primary Physician:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

**Emergency Physician:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

**Medical Conditions:** (e.g., diabetes, epilepsy, heart conditions, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Disabilities:** \_\_\_\_\_

**Allergies:** (e.g., hay fever, strawberries, peanuts, etc.) \_\_\_\_\_

\_\_\_\_\_

**Medications:** \_\_\_\_\_

**Allergies to Medications:** \_\_\_\_\_

**Medicines to be Self-Administered by the Child: (See Below):** \_\_\_\_\_

\_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Medicines to be Administered by the School (IF parents/guardians and school both agree that school shall do so; see below):** \_\_\_\_\_

\_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_