St Cyril of Alexandria Youth Ministry
Emergency Medical Form

Name: _____
First Middle Last
Mailing Address: _____
City: _____ Zip: _____ Phone: _____

Medical History: _____
Medications: _____
Allergies: _____

Physician: _____ Physician's Phone Number: _____
Dentist: _____ Dentist's Phone Number: _____
Preferred Hospital: _____

Insurance Carrier: _____
Subscriber ID: _____
Group Number: _____

In Case of an Emergency Please Notify:
Parent: _____ Phone Number: _____
Address: _____
Cell Phone: _____

Alternate Guardian:
Name: _____ Relationship to child: _____
Address: _____
Phone Number: _____ Cell Phone: _____

I, _____, the parent/guardian of _____ give my permission for Medical Transportation and Treatment to be given to my child in case of a medical emergency. I understand that these may do whatever is necessary to stabilize my child until I am contacted.

_____ _____
Signature Date