



# Holy Rosary Church

344 Sixth Street, Jersey City, New Jersey 07302

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www.HolyRosaryChurch.com

*"Celebrating 137 years as the First Italian Parish in the State of New Jersey."  
Established in 1885*

## Medical Information Form School Year 2022-2023

In the event of minor illness/accident, early dismissal or other changes in class routine, I request that the Religious Education staff contact me using the information provided on this form. If the staff is unable to reach me, I hereby authorize them to contact the adults listed below who may assume temporary care of my child.

Student Name: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Parent/Guardian Home Address: \_\_\_\_\_

Parent Phone Numbers to call in case of emergency:

(1) \_\_\_\_\_ (2) \_\_\_\_\_

(please indicate home or cell)

### **Emergency Contact Information (2 people other than the parent/guardian listed above):**

1. Name: \_\_\_\_\_

Numbers to call in case of emergency:

(1) \_\_\_\_\_ (2) \_\_\_\_\_

2. Name: \_\_\_\_\_

Numbers to call in case of emergency:

(1) \_\_\_\_\_ (2) \_\_\_\_\_

Does your child have any special educational needs?  Yes, please describe below  No

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**(OVER)**

**Medical Information**

Please list any health concerns or allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of an emergency, please list any medication your child is currently taking:

*Note: The Religious Education staff will not administer any medication, but would pass this information on to medical personnel if the need arises.*

In case of an accident or serious illness, I request that the Religious Education staff of Holy Rosary Church contact me using the information provided on this form. If the staff is unable to reach me, I hereby authorize the Religious Education staff of Holy Rosary Church to call the physician indicated below and to follow his or her instructions. If the Religious Education staff is unable to reach the parent, guardian, emergency contact, or physician, then you are authorized to make any and all appropriate arrangements deemed necessary for the safety and care of my child, including transporting my child to the nearest hospital emergency room by ambulance.

Name of Your Child's Physician: \_\_\_\_\_

Physician's Telephone No: \_\_\_\_\_

**Please indicate your approval of the information provided on this form by printing and signing your name below:**

**Name of parent/guardian (please print)** \_\_\_\_\_

**Signature of parent/guardian (please sign)** \_\_\_\_\_