Holy Rosary Church

344 Sixth Street, Jersey City, New Jersey 07302
Tel: 201-795-0120 Fax: 201-795-3230
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 2023 -2024

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

____

____

____

(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)____