

**St. Thomas Aquinas Church and Student Center**  
**MEDICAL RELEASE FORM**

Name of Participant \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

*The undersigned do/does hereby give permission for our/my child \_\_\_\_\_ to attend and participate in all activities sponsored by St. Thomas Aquinas Religious Education and Youth Ministry Programs for the 2008-2009 academic year.*

*In the event of an emergency, if we/I am unable to be contacted for my consent, I authorize an adult whose care the minor has been entrusted to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.*

*The undersigned shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to aforementioned child pursuant to this authorization.*

*If an adult who has been entrusted with the care of our/my child determines it to be necessary that our/my child return home due to medical or other reasons, the undersigned shall assume all transportation costs.*

*The undersigned does also hereby give permission for our/my child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities by St. Thomas Aquinas Religious Education and Youth Ministry Programs.*

Hospital Insurance \_\_\_\_\_ yes \_\_\_\_\_ no Policy Number \_\_\_\_\_

Insurance Company \_\_\_\_\_

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please list below any allergies or special medical needs/problems your child may have.