IMMACULATE HEART OF MARY
Children's Faith Formation

22375 Three Notch Road Lexington Park, Maryland 20653

CFF YEAR: _____

All Parents/Guardians are required to complete this FORM for EACH child

EMERGENCY / MEDICAL INFORMATION

NAME OF CHILD: _____ CFF Level: _____

In the event that the undersigned, emergency contacts, or my physician cannot be reached and in the judgment of the Coordinators of Religious Education or other appropriate staff member, there is necessity for immediate examination and/or treatment of my child. I hereby request and authorize any of the CFF or Parish personnel to obtain for my child such medical services as deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

THIS RELEASE IS VALID UNTIL JUNE 30, 20_____

Parent/Guardian Name # 1: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Parent/Guardian Name # 2: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

MEDICAL INFORMATION

Diagnosed Health Related Conditions: _____

Allergies: _____

Current Medications: _____

Activity Restrictions: _____

In case your child is ill and we are unable to contact you, please provide the name of a relative or friend whom we may call.

Emergency Contact Name # 1:_____
Home Phone: _____
Cell Phone: _____
Relationship to Child: _____

Emergency Contact Name # 2:_____
Home Phone: _____
Cell Phone: _____
Relationship to Child: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

IHM Office of Religious Education Signature: _____ Date: _____