ST. JUDE'S PRESCHOOL

4100 Lyell Road
Rochester, New York 14606
Office (585) 426-1872 Fax (585) 429-5111

HEALTH FORM

Name of Participant: _____ Phone: _____

Street Address: _____

Town/City: _____ Zip: _____

Date of Birth: _____

Parish and Location: _____

Emergency Contact: _____ Phone: _____

Relationship to Participant: _____

Health Insurance Company: _____ Policy No. _____

Family Physician/Clinic: _____ Phone: _____

Please list any allergies or special needs:

_____

_____

_____

Is there anything else we should know about your child?

_____

_____

_____

In signing this health form, I hereby certify that the above information is correct and I give permission for my child to be transported in privately owned vehicles for medical and other emergency purposes only and for the release of medical records to an attending physician in case of illness.
In case of medical emergency, I understand that every effort will be made to contact the parents or guardian. In the event that I cannot be reached, I hereby give permission to the physician selected to secure proper treatment for my child named herein.

Signature of parent/guardian: _____ Date: _____

Phone No. _____