

SAINT THOMAS AQUINAS ACADEMY

SECONDARY CAMPUS

Name _____ Age _____ Date of Birth _____ Grade _____

Address _____ Phone _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

Insurance Company _____ Policy # _____

Person to contact if parent/guardian cannot be reached:

Name _____ Phone _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Permission to Treat

Allergies _____

Medications _____ Contact Lenses: Yes/No _____

Medical Conditions _____

Date of Last Tetanus Shot _____

We/I the parent(s)/guardian(s) of _____
give permission for emergency medical treatment of this child in case of illness or accident.

Date _____ Parent/Guardian _____