DIOCESE OF PATERSON
Health Information and Consent to Treat Form

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

Name of Parent (s)/Guardian(s): _____

Home Phone # _____ Work Phone # _____

Health Insurance Co: _____ Policy: _____

Grade: _____ Birth Date: _____ Male/Female: _____

Parish: _____ Parish City: _____

Are you currently under the care of a doctor, psychologist or psychiatrist? _____

Name of Family Physician: _____ Phone #: _____

Last Tetanus shot: _____ Allergies to Drugs or Food: _____

Do you have special dietary needs or restrictions? _____

Special Medications, blood type or pertinent medical information: _____

_____

_____

I/we have read the foregoing Health Information and Consent to Treat Form and the answers are all correct.

I/we can be reached at the telephone numbers referred to above but if emergency medical care or treatment shall be necessary and if I/we cannot be reached, I/we authorize the delegated agents of the Diocese of Paterson to act on my/our behalf and approve appropriate treatment. I/we understand that I/we remain responsible for my/our child's medical expenses.

_____ _____

Date Parent or Guardian

_____ _____

Date Parent or Guardian