

**Medical Release Form 2017-2018**

**ST. BERNARD OF CLAIRVAUX  
ST. STANISLAUS KOSTKA  
368 Sumner Avenue, Plainfield 07062  
(908) 756-3393 Fax (908) 756-3059**

Child's Name (s): \_\_\_\_\_

Child's Name (s): \_\_\_\_\_

Child's Name (s): \_\_\_\_\_

Child's Name (s): \_\_\_\_\_

Child's Name (s): \_\_\_\_\_

\* Doctors Name: \_\_\_\_\_

Doctors address: \_\_\_\_\_

Doctor's Phone \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

\*Indicate if more than one doctor and for which child.

**In case of a medical emergency, I give St. Bernard of Clairvaux and St. Stanislaus Kostka authorization to take my child for emergency medical care.**

Date: \_\_\_\_\_ **PRINT PARENT NAME:** \_\_\_\_\_

**PARENT SIGNATURE** \_\_\_\_\_

**Tel. No.** \_\_\_\_\_

**Cell No.** \_\_\_\_\_