

**EXTENDED DAY CARE MEDICAL RELEASE FORM**

(Please print)

Family Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last Middle First

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

As the Parent/Legal Guardian, I give the Immaculate Conception School Extended Day Care Program consent to provide for my child all emergency medical or dental care prescribed by a duly licensed physician (M.D.) or dentist (D.S.). This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my child.

Physician or dentist to be called in emergency:

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

The above named child takes the following medication regularly:

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date