Our Lady of Mercy Academy

Educating young women with Faith, Compassion, and Promise

General Permission Form

Name: _____ Trip to: _____

Address: _____ Town: _____ State: _____ Zip: _____

Parent or Guardian: _____

Address (if different): _____

Telephone Number: Cell: _____ Home: _____ Work: _____

Emergency Contacts if Parent or Guardian cannot be reached:

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

Medical History: *Please note all information in this section is confidential.*

Does the student have any medical or emotional conditions requiring special attention? ☐ Yes ☐ No

If yes, please specify: _____

Does the student have any allergies or medical reaction we should know about? ☐ Yes ☐ No

If yes, please specify: _____

Insurance Information:

Insurance Plan or Program Name: _____

Insured's Name: _____

Insured's Policy Group or FECA Name: _____

Insured's or Authorized Person's Signature to authorize payment of medical benefits to the designated physician or supplier of services needed: _____ Date: _____

The undersigned parent or guardian of (student's name) _____ authorizes the chaperones representing Our Lady of Mercy Academy to obtain medical care for her in the event such care is necessary. If possible, the parent(s) or guardian of the above named individual will be contacted in the event of an emergency. Permission is hereby granted to the licensed physician or accredited hospital and their associated to perform any medical and/or surgical procedures that are deemed essential to the treatment of the above named individual. We also agree to be responsible for payment of such care.

Signed: _____ Date: _____