Holy Family Academy

Ad Majorem Dei Gloriam

P.O. Box 842, Mount Angel, Oregon 97362 Telephone: 503-792-3630

Medical Form: Student Information and Deferral Statement

Student Name ____
(Last) (First) (MI)

Date of Birth ____

Home Address ____

Telephone Numbers:

Home:__________________ Work: __________________
(Father)

Cell:__________________ Work: __________________
(Mother)

Person(s) to be contacted in the event of an emergency and parents cannot be reached:

____
(Name) (Relationship)

____
(Name) (Relationship)

Family Doctor:____
(Name) (Phone)

Address:____

Please list any important medical information or allergic reactions:

____

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We hereby understand that Holy Family Academy is not providing medical insurance for our child and that any health care that is necessary will be provided at our own cost. In the event of an emergency, we authorize the person in charge at Holy Family Academy at the time, to contact the nearest medical doctor or facility for assistance as deemed necessary.

Signed: ____
(Father/Guardian) (Date)

Signed: ____
(Mother/Guardian) (Date)