Immaculate Conception Church

305 East Howard St
Colfax, IA 50054
515.674.3711
imcolfax@msn.com

Immaculate Conception Faith Formation
Family - Medical Registration

Please fill in all information below. Then fill out one student registration for each child.

Parent/Guardian: _____

Address: _____

Address Line 2 _____

City State Zip Code: _____

Home phone: _____

Work phone: _____

Mobile phone: _____

Family Email: _____

Medical Insurance Carrier: _____

Policy Number: _____

Emergency Contact Person: _____ **Phone:** _____

I (we), the parent(s) / guardian(s) of _____
(Please list the names of your children)
authorize the representatives of Immaculate Conception Parish, as my (our) agent, to consent to any emergency examination, x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by and rendered under the supervision of a licensed physician or surgeon. I (we) have noted below any special health concerns or medication involving the named minor(s). By signing, I hereby consent to sharing the medical information below with any adult involved in the Immaculate Conception Parish Faith Formation program for the benefit of my (our) child(ren).

List any medications or conditions affecting any of your children.

Signature_____ date _____