

## Parental/Guardian Medical Information & Consent Form

Applicant Information				
Participant's Name:			Date of	Birth:
Address:	City	y: State:	Zip:	Phone:
Father's Name:		Phone:	•	
Mother's Name:		Phone:		
Emergency Contact:		Languages Spoken by Emergency Contact:		
Medical Matters				
I hereby warrant to the best of my knowledge, all the information provided is true and correct and I assume all responsibility for the				
health of my child. I understand it is my responsibility to update the Medical Information & Consent Form if there are any changes to				
my child's health. (Please initial)				
Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for				
Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment. ( <i>Please initial</i> )  Family Doctor: Phone:				
Family Doctor:	Phone:			
Medications: I hereby Grant Permission for my child to be given the following provided medications. All medications must be well				
labeled. [NOTE: Any/all prescription medications must be in original pharmacy container with young person's name on the				
prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the				
container.] I release and hold harmless (entity name) ALL SOULS CATHOLIC CHURCH, the Diocese of Orlando and any other religious,				
employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication.				
(Please initial)				
Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as				
follows:				
Medication:	Dosage:		Administ	er:
Medication:	Dosage:		Administ	er:
Medication:	Dosage:		Administ	er:
Medical Conditions Information: (Reasonable steps will be taken to keep this information confidential, but it will be shared with				
Diocesan personnel and others, as warranted.) My son/daughter:				
Is allergic to the following medications				
Has had an episode of the following or has been diagnosed with: □ Seizures □ Asthma □ Diabetic				
Has had allergic reactions to the following (foods, dyes, latex, etc.)				
Has had a medical surgery within the last six months? □ Yes □ No Still under doctor's care? □ Yes □ No				
Has a medically prescribed diet (please explain)				
Has the following physical limitations				
■ Immunizations current and up to date? □ Yes □ No Date of last tetanus/diphtheria immunization				
You should also be aware of these special medical conditions of my child:				
Insurance Information				
☐ No, I do not carry medical insurance at thi	s time.	Insurance Carrier:		
☐ I do carry medical insurance at this time.				
Name of Insured:		Insurance Policy Nu	mber:	
In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's				
parent/guardian.				
		<u></u>		
Parent/Guardian Signa	ture			Date
(must sign for any participant under 18 or 18 o	or older & in high schoo	<i>l</i> )		