ST. PETER CONFIRMATION PREPARATION

MEDICAL INFORMATION AND CONSENT FORM 2019-2020

GENERAL INSTRUCTIONS TO PARENTS/GUARDIANS/ADULTS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
2. **Sections I, II and V are mandatory**. Sections III and IV provide you with treatment options in non-emergency situations.

CHILD or ADULT (choose one):____________________________ Parent: __________________________________ Participant's Birth date: ____________

Sex:_________________ E-Mail ____

Home address: ____

(Street) (City/State) (Zip)

Home phone: _______________________Cell phone: _______________________ Business phone: _______________________

SECTION I. **MEDICAL MATTERS**

As the **PARENT / LEGAL GUARDIAN / ADULT** (choose one) who is currently associated with St. Peter Confirmation Preparation, I hereby authorize The Coordinators and/ or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from September 1, 2019, through October 31, 2020. I hereby warrant that, to the best of my knowledge, said person is in good health, and I assume all responsibility for the health of said person.

Signature: ____ Today's Date: _________________________

SECTION I I . **EMERGENCY MEDICAL TREATMENT**

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the numbers listed herein, contact:

Name & Relationship:____ Phone:______________________

Family doctor: ____ Phone: ______________________

Family Health Plan Carrier: ____Policy #: _____________________

Signature:____ Date: ________________________

SECTION III: **OTHER MEDICAL TREATMENT**

In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of New Orleans, chaperones, or representatives associated with the activity that said person becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: ____ Date: ______________________

SECTION IV: **MEDICATIONS** ***(Sign only those options that are applicable)***

- Said person is taking medication at present. Said person will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the said person takes such medications, including dosage and frequency of dosage, are as follows: ____

  Signature:____Date:________________

- I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to said person, if deemed appropriate.

  Signature: ____Date:_________________

- NO medication of any type, whether prescription or non-prescription, may be administered to said person unless the situation is life-threatening and emergency treatment is required.

  Signature: ____Date:____________

SECTION V: **MEDICAL INFORMATION**

The parish will take reasonable care to see that the following information will be held in confidence. Allergic reactions (medications, foods, plants, insects, etc.): ____ Immunizations: Date of last tetanus/diphtheria immunization: ____________ Does said person have a medically prescribed diet? ______________________ Any physical limitations?

____

Is said person subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? ________ Has said person recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? ____________ If so, date and disease or condition:____ You should be aware of these special medical conditions of said person: ____.