

**ST. PETER CONFIRMATION
MEDICAL INFORMATION AND CONSENT FORM 2021**

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: _____

Home phone: _____ (Street) _____ (City/State) _____ (Zip)
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 August 29, 2021, through November 2, 2021. 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 II. 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: _____