# *Medical Information*

Dear Parents,
In order to account for all possible and unforeseen circumstances, it is important to obtain permission from you that, in the event of a medical emergency, your child would be able to receive medical attention. Please sign and fill in the following confidential information.

## Child Information

Member's Name______________________________________________________________

Street Address________________________________________________________________

City________________________________________ State______________ Zip_______________

Home Telephone Number____________________________ Date of Birth______________

## Parent Information

Father's Name____________________________________________ Cell Phone_______________

Mother's Name___________________________________________ Cell Phone_______________

**Alternate people to notify -** List two neighbors or relatives who will assume temporary care and who may authorize or refuse medical treatment for your child in case you cannot be reached.

Name_____________________________________________ Relationship_______________

Address___________________________________________ Phone____________________

Name_____________________________________________ Relationship_______________

Address___________________________________________ Phone____________________

## Present Medical Information

1. Is your child allergic to bee stings? Yes No

2. Is your child allergic to any medications? Yes No
   List________________________________________________________________
   ____________________________________________________________________

3. List any other allergies known.
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   If allergies are known, does your child carry an Epi-Pen on them?____________________

4. Does your child have Asthma? Yes No

   If yes, is a medicated inhaler required? Yes No
   If yes, does your child carry an inhaler? Yes No

5. Date of Last Tetanus Shot ____________________

6. Contacts or glasses worn? Yes No If so, which __________

4. List any special health/medical conditions that an attending medical person should be aware of, ie., heart murmur, diabetes, etc.:
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

5. Presently on prescription medication? (If so, what? Include dosage and any other pertinent information.)
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

9. Additional Medical History
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

## Physicians' Information

Primary Physician ________________________________ Office Phone

Orthopedist ____________________________________ Office Phone

## Insurance Information

Insurance Company Name___________________________________________________________

Subscriber's Name_________________________________________________________________

Identification Number__________________________Group Number_________________________

Policy Number____________________________________________________________________

Type ___________________________________________ Effective Date

## Consent for treatment

If emergency treatment is required and none of the above can be contacted, may the church authorities use their own judgement in sending the child to the hospital or doctor most easily accessible or make whatever arrangements are necessary.
Yes _______ No _______

## Photo Consent

We frequently take photos on our retreats/events and use them to promote future events. Your child's name will never be posted along with the photos. By agreeing to this, you are permitting us to use any photos taken on our retreat/event in the future without further consent.

Agree _________ Disagree ______

Parent(s) Signature(s) __________________________________________ Date

Thank you,

Brian Salvatore
Youth Minister, Our Lady of Perpetual Help