

## FORM 2 – MEDICAL INFORMATION & RELEASE

Catholic Diocese of Shreveport and/or the Church of \_\_\_\_\_

Participant's name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Specific Medical Information**

1. You should be aware of these special medical conditions and/or needs (e.g. physical, developmental, behavioral, cognitive, or other diseases, disabilities, disorders or limitations): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on back if needed)

2. Allergic reactions (medications, foods, plants, insects, latex, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on back if needed)

### **Medications:**

- This child takes no medication and will bring no medication with him/her.
- This child takes medication/s and will self-medicate. All medications will be clearly labeled. The child will be required to surrender all medication(s) to a designated adult. It will be this child's responsibility to appear at the designated location and times listed below to obtain the medications. At the conclusion of the event, it will be this child's responsibility to retrieve remaining medication(s) from the designated adult. Names of medications and exact dosage and frequencies/times are as listed below: (Attach a sheet to this form if you need more space.):
- This child takes medication but shall not self-medicate. The parent/guardian will provide and dispense medications.

**In case of an emergency** and for permission for treatment of the participant beyond emergency procedures, please contact:

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

By signing below, I, \_\_\_\_\_ confirm that, to the best of my knowledge, I or the above named child am/is in good health and I take full responsibility for my or the above named child's health. I confirm that the Diocese of Shreveport and/or the church listed above has my full and complete permission to seek and obtain medical attention for myself or the above named child in the event of any accident or illness which may occur, including the authorization to consent to emergency medical care, if required during any diocesan or church events between the **1st day of August, 2021 through the 31st day of August, 2022**. I understand that reasonable efforts will be made to advise parents, guardians or emergency contacts of my or the above named child's condition prior to any treatment.

I acknowledge and agree that it is my responsibility to inform the Diocese of Shreveport and or the church listed above if at any time any of the above information needs to be changed, amended, or updated prior to the expiration date of this Medical Consent. I also confirm that to the best of my ability, I have not omitted any pertinent information, everything I have stated herein is true, and accurately reflects my wishes.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_