MEDICAL CONSENT Please complete one per child/teen

Full Name of Child _____

Medical Matters

I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

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 and you are unable to reach me, contact:

Name & Relationship _____ Phone_____

Medications:

Family Doctor _____Phone_____

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

Medication(s):_____Dosage: _____

Administer: _____

_I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has had an episode of the following or has been diagnosed: ☐Siezures Asthma ☐ Diabetic

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? _____

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

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: _____

Name of Insured: _____

Insurance Policy Number: _____

Father's Name: Day Phone: _____

Mother's Name: Day Phone: _____

____No, I do not carry medical insurance at this time.

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____

Signature (Parent/Guardian) **Date**

_____ _____

Signature (Participant 18 years of age or older must sign own consent) **Date**