
Please fill in ALL blanks below. If the answer is none or does not apply, write none or N/A in that blank. Every line needs response

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, mark 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 and I understand that all financial obligations are my responsibility.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship: _____ Phone: _____

Family Doctor: _____ Phone: _____

Medications

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:

My child is taking the following medication at the present time.

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:

Has had an episode of the following or has been diagnosed: Seizures Asthma Diabetic (Circle all that apply)

Allergic reactions to the following (food, dyes, latex etc.) _____

Has a medically prescribed diet? _____

The following physical limitations? _____

Immunizations current and up to date: Yes No (Please circle) Date of last tetanus/diphtheria immunization _____

You should also be aware of these special medical conditions of my child (e.g. depression, anxiety, etc.):

Parent(s) or Guardian(s) Signatures Date Signed

Insurance Company: _____

Information

Policy Carrier (Name Employer or Individual): _____

Policy Number: _____

Video/Photography Consent

As parent/guardian, I understand that promotional pictures and videos (individual and group) will be taken during diocesan events. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web page, calendars, power point, video etc.) in highlighting diocesan events.

Signature (Parent/Guardian)

Date

A PHOTOCOPY OF BOTH SIDES OF MAJOR MEDICAL INSURANCE ID CARD MUST BE ATTACHED.