MEDICAL CONSENT

_____
Name of student

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 to your wishes:

Emergency Medical Treatment
In the event of any 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 any emergency when you are unable to reach me, contact:

Name & Relationship _____ Phone _____
Family Doctor _____ Phone _____

Medications
My child will bring all medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequencies are as follows:
My child is taking the following medication at the present time:

Medication(s)_____ Dosage_____ Medication_____ Dosage_____

Medication_____ Dosage_____

Administer _____

_____ I hereby **DO NOT GRANT PERMISSION** for medication of any type, whether prescription or nonprescription to be administered to my child unless the situation is life threatening and emergency treatment is required. (Please initial
_____ I hereby **GRANT PERMISSION** for nonprescription medication provided by the parent(s)/guardian(s) (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. (Please initial)

MEDICAL CONDITIONS INFORMATION
(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)
My child has _____
Has had an episode of the following or has been diagnosed? ☐ Seizures ☐ Asthma ☐ Diabetic
Allergic reactions to the following (foods, dyes, latex, etc.) ? _____
Has had medical surgery within the last six months? ☐ Yes ☐ No Still under Doctor's care? ☐ Ye ☐ 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 be aware of these special medical conditions of my child. _____

INSURANCE INFORMATION
Insurance Carrier _____
Name of Insured _____
Insurance ID Number _____ Insurance Policy Number: _____
Father's Name _____ Birth Date: _____
Place of Employment _____
Mother's Name _____ Birth Date: _____
Place of Employment: _____

☐ 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, or diarrhea, I want to be called immediately.

_____ _____
Signature (Parent/Guardian) **Date**
Parent/ Guardian must sign for anyone under 18 years of age

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