Medical Consent and Permission to Treat

I hereby warrant that 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 that are applicable.

Insurance Information:
Family health plan carrier: _____ Policy number: _____

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.

Signature of Parent/Guardian: _____ Date: _____

In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name: _____

Relationship: _____ Phone: ( ) _____

My child is under the care of a medical provider: ❑ Yes ❑ No

Provider name: _____ Phone: ( ) _____

Other Medical Treatment:
In the event it comes to the attention of the parish, its officers, directors and agents, and the chaperones or representatives associated with the activity, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ Date: _____

READ AND SIGN IF YOUR CHILD IS TAKING MEDICATION AT PRESENT.
My child will bring all such medications necessary, and such medications will be well-labeled in a resealable bag. The bag must include instructions from the parent/guardian on how and when medication/treatments should be taken. Medications will be stored by the supervising adult leader in a secure area. At the prescribed times, youth can take their medications/treatments in the presence of a supervising adult leader. **Medications/treatments that require any form of disrobing must be self-administered by the student privately**. Exceptions to this policy are medications that need to be in the constant possession of the youth (e.g. insulin, inhalers or epinephrine pens).

Signature: _____ Date: _____

Specific Medical Information:
The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Date of last tetanus/diphtheria immunization: _____

Does your child have a medically prescribed diet? ❑ Yes ❑ No

Any physical limitations? ❑ Yes ❑ No

Is your child subject to chronic homesickness, emotional reactions to new situations, sleepwalking or fainting?
❑ Yes: _____ ❑ No

Has your child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.?
❑ Yes ❑ No

If yes, list date and disease/condition: _____

You should be aware of these special medical conditions of my child: _____

_____

_____

Signature: _____ Date: _____