MEDICAL CONSENT

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: _____

Family Doctor: _____ Phone: _____

MEDICAL CONDITIONS INFORMATION (Diocesan personnel will take responsible care to see that the following information will be held in confidence.) If more than 3 children, please use an additional form			
	Child # 1	**Child # 2**	**Child # 3**
Full Name (*as on Birth Certificate*)			
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: Dosage: Administer:	Medication: Dosage: Administer:	Medication: Dosage: Administer:
I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required. (Please initial)			
OR	***Please Initial***	***Please Initial***	***Please Initial***
I hereby **Grant Permission** for nonprescription medication (such as Tylenol/Advil, throat lozenges, cough syrup, Imodium) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)			
	Please Initial	***Please Initial***	***Please Initial***
My child has had an episode or been diagnosed with:	❑ Seizures ❑ Diabetic ❑ Asthma ❑ Other-Explain	❑ Seizures ❑ Diabetic ❑ Asthma ❑ Other-Explain	❑ Seizures ❑ Diabetic ❑ Asthma ❑ Other-Explain
My child has had allergic reactions to the following foods, dyes, latex, medication, etc:			
	Please list, if none put NA	***Please list, if none put NA***	***Please list, if none put NA***
Does your child need to carry an EPI Pen? And if so, can child administer to himself/herself?			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
My child as had a medical surgery within the last six months			
	❑ Yes ❑ No If yes, explain:	❑ Yes ❑ No If yes, explain	❑ Yes ❑ No If yes, explain
My child has a medically prescribed diet			
	❑ Yes ❑ No If yes, explain:	❑ Yes ❑ No If yes, explain	❑ Yes ❑ No If yes, explain
My child has the following physical limitations			
	Please list, if none put NA	***Please list, if none put NA***	***Please list, if none put NA***
My child's immunizations are current	❑ Yes ❑ No Date of last tetanus/diphtheria	❑ Yes ❑ No Date of last tetanus/diphtheria	❑ Yes ❑ No Date of last tetanus/diphtheria
You should also be aware of these special medical conditions	***Please list, if none put NA***	***Please list, if none put NA***	***Please list, if none put NA***

INSURANCE INFORMATION

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

Insurance Carrier: _____ Father's Name: _____

Insurance Policy Number: _____ Father's Day Phone: _____

Name of Insured: _____ Mother's Name: _____

Day Phone: _____

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**