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 son/daughter is under the care of a medical provider. _____Yes _____No
Provider Name: _____Phone Number: ( )_____

Other Medical Treatment*:* In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of New York, chaperons, or representatives associated with the activity, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea,
Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____
_____
_____
Signature: _____Date: _____

OR No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.
Signature: _____Date: _____

I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.
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.): _____
Immunizations: Date of last tetanus/diphtheria immunization: _____
Does child have a medically prescribed diet? _____
Any physical limitations? _____
Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.?
If so, list date and disease or condition: _____
You should be aware of these special medical conditions of my child: _____
_____