



Parental/Guardian Medical Information & Consent Form

Applicant Information				
Participant's Name:			Date of Birth:	
Address:	City:	State:	Zip:	Phone:
Father's Name:		Phone:		
Mother's Name:		Phone:		
Emergency Contact:		Languages Spoken by Emergency Contact:		

Medical Matters	
<p>I hereby warrant to the best of my knowledge, all the information provided is true and correct and I assume all responsibility for the health of my child. I understand it is my responsibility to update the Medical Information & Consent Form if there are any changes to my child's health. <i>(Please initial)</i> _____</p> <p>Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment. <i>(Please initial)</i> _____</p>	
Family Doctor:	Phone:
<p>Medications: I hereby Grant Permission for my child to be given the following provided medications. All medications must be well labeled. [NOTE: Any/all prescription medications must be in original pharmacy container with young person's name on the prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the container.] I release and hold harmless (entity name) _____, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication. <i>(Please initial)</i> _____</p> <p>Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as follows:</p>	

Medication:	Dosage:	Administer:
Medication:	Dosage:	Administer:
Medication:	Dosage:	Administer:

<p>Medical Conditions Information: (Reasonable steps will be taken to keep this information confidential, but it will be shared with Diocesan personnel and others, as warranted.) My son/daughter:</p> <ul style="list-style-type: none"> • Is allergic to the following medications _____ • Has had an episode of the following or has been diagnosed with: <input type="checkbox"/> Seizures <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetic • Has had allergic reactions to the following (foods, dyes, latex, etc.) _____ • Has had a medical surgery within the last six months? <input type="checkbox"/> Yes <input type="checkbox"/> No Still under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No • Has a medically prescribed diet <i>(please explain)</i> _____ • Has the following physical limitations _____ • Immunizations current and up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last tetanus/diphtheria immunization _____ • You should also be aware of these special medical conditions of my child: _____ 	
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Insurance Information	
<input type="checkbox"/> No, I do not carry medical insurance at this time. <input type="checkbox"/> I do carry medical insurance at this time.	Insurance Carrier:
Name of Insured:	Insurance Policy Number:

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.

Parent/Guardian Signature <i>(must sign for any participant under 18 or 18 or older & in high school)</i>	Date
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