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

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. (*Please initial*) _____

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. (*Please initial*) _____

Family Doctor:	Phone:

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) St. Joseph Catholic Church, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication. (*Please initial*) _____

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:

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:

- Is allergic to the following medications _____
- Has had an episode of the following or has been diagnosed with: □ Seizures □ Asthma □ Diabetic
- Has had allergic reactions to the following (foods, dyes, latex, etc.) _____
- Has had a medical surgery within the last six months? □ Yes □ No Still under doctor's care? □ Yes □ No
- Has a medically prescribed diet (*please explain*) _____
- Has the following physical limitations _____
- Immunizations current and up to date? □ Yes □ No Date of last tetanus/diphtheria immunization _____
- You should also be aware of these special medical conditions of my child:

Insurance Information

□ No, I do not carry medical insurance at this time. □ 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 _____ Date

(must sign for any participant under 18 or 18 or older & in high school)