Diocese of Orlando Parental/Guardian Medical Information & Consent Form

Participant's Name:	Date of Birth:	Homeroom:
Address:	C/S/Z:	
Home/Primary Phone:	Primary Language Spoken:	

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

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. *Acknowledged by*: _____

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. *Acknowledged by*: _____

Family Doctor: Doctor's 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 Morning Star Catholic School, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication.
Acknowledged by: _____

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:
*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:
- Has had allergic reactions to the following (foods, dyes, latex, etc.):
- Has had a medical surgery within the last six months? No Yes Still under doctor's care? No Yes
- Has a medically prescribed diet:
- Has the following physical limitations:
- Immunizations are current and up to date, unless expiration or notes are shown here:
- Date of tetanus/diphtheria immunization(s):
- You should also be aware of these special medical conditions of my child:

Insurance Information

I 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.

I fully understand the foregoing statements and sign this Medical Information & Consent Form knowingly, freely, and willingly.
Parent/Guardian Name: (PRINT)_____ Date:_____

Signature required below when medications are left at school and/or for changes to the above information Date