



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. <i>(Please initial)</i> _____ 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> _____				
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) _____, 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> _____ 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 <i>(please explain)</i> _____ - 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 <i>(must sign for any participant under 18 or 18 or older & in high school)</i>	_____ Date
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