Diocese of Orlando Parental/Guardian Medical Information & Consent Form

Participant's Name:______________________________________ Date of Birth:________________________

Address____ City/State/Zip________________________________

Home Phone:____________________

Father's Name: ____________________________________ Phone: _____________________________

Mother's Name: ___________________________________ Phone: _____________________________

Emergency Contact Name: _____________________________ Phone: ________________________________

Language 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) ___________________, 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.

I fully understand the foregoing statements and sign this Medical Information & Consent Form knowingly, freely, and willingly.

____ ______________________________

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

4/2013