

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: _____

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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