



Parental/Guardian Medical Information & Consent Form

APPLICANT INFORMATION

Participant's Name _____

Date of Birth: _____

Address _____

City _____ State _____ Zip _____

Father's Name _____ Phone _____

Mother's Name _____ 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 that it is my responsibility to update the *Parental/Guardian Medical Information & Consent Form* if there are any changes to my child's health.

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.

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.

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 a doctor’s care?

- Has a medically prescribed diet (please explain) _____
- Has the following physical limitations _____
- Immunizations 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

Do you have medical insurance? Yes No

If yes, please provide the following information.

Insurance company _____

Policy in the name of _____

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.

In signing the line below, I certify all the information on this form is complete and accurate, By consenting to the use of an electronic signature, I am agreeing to the rights and obligations in this *Parental/Guardian Medical Information & Consent Form*. I can obtain a copy of the electronically signed *Parent/Guardian Medical Information & Consent Form* by requesting a copy from the

_____ *(Parish/Diocese/School)*
where I submitted the document. If I prefer, I can, by printing the document, obtain a paper copy of the *Parental/Guardian Medical Information & Consent Form*, sign it by hand, and deliver it to _____

_____ *(Parish/Diocese/School)*
I can withdraw my consent to *Parental/Guardian Consent Form & Liability Waiver* by notifying

_____ *(Parish/Diocese/School)*
in writing. Consent cannot be withdrawn for _____ *(event)*
once _____ *(event)*

has commenced. If I withdraw my consent, I and/or my child will not be able to attend

_____ *(event)*
Even if consent is withdrawn, I understand I may still be liable for the

_____ *(cost of the event OR fees already incurred)*

Signature

Date