SIGN ONLY THOSE THAT ARE APPLICABLE:

EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby give permission to transport my child to a hospital emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name and Relationship: _____ Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

OTHER MEDICAL TREATMENT

In the event it comes to the attention of PARISH/SCHOOL*, its officers, directors, and agents, and the* DIOCESE OF STEUBENVILLE*, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).*

Signature: _____ Date: _____

MEDICATIONS (check and complete all that apply)

☐ *My child is taking medications at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:*

_____

_____

Signature: _____ Date: _____

☐ *No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.*

Signature: _____ Date: _____

☐ *I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.*

Signature: _____ Date: _____

SPECIFIC MEDICAL INFORMATION

The PARISH/SCHOOL *will take reasonable care to see that the following information will be held in confidence.*

1. Allergic reactions (medications, foods, plants, insects, etc): _____
2. Date of last tetanus/diphtheria immunization: _____
3. Does the participant have a medically prescribed diet? _____
4. Any physical limitations? _____
5. Is the participant subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting, etc.? _____
6. Has the participant recently been exposed to contagious disease/condition, such as mumps, measles, chickenpox, etc.? If so, date and disease/condition: _____
7. You should be aware of these special medical conditions of my child: _____