



# 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	
<p>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 &amp; Consent Form if there are any changes to my child's health. <i>(Please initial)</i> _____</p> <p><b>Emergency Medical Treatment:</b> 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> _____</p>	
Family Doctor:	Phone:
<p><b>Medications:</b> I hereby <b>Grant Permission</b> 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> _____</p> <p>Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as follows:</p>	

Medication:	Dosage:	Administer:
Medication:	Dosage:	Administer:
Medication:	Dosage:	Administer:

<p><b>Medical Conditions Information:</b> (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:</p> <ul style="list-style-type: none"> <li>• Is allergic to the following medications _____</li> <li>• Has had an episode of the following or has been diagnosed with: <input type="checkbox"/> Seizures <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetic</li> <li>• Has had allergic reactions to the following (foods, dyes, latex, etc.) _____</li> <li>• Has had a medical surgery within the last six months? <input type="checkbox"/> Yes <input type="checkbox"/> No      Still under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Has a medically prescribed diet <i>(please explain)</i> _____</li> <li>• Has the following physical limitations _____</li> <li>• Immunizations current and up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of last tetanus/diphtheria immunization _____</li> <li>• You should also be aware of these special medical conditions of my child: _____</li> </ul>	
---	--

Insurance Information	
<input type="checkbox"/> No, I do not carry medical insurance at this time. <input type="checkbox"/> 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 &amp; in high school)</i>	Date
--	------