

\_\_\_\_\_  
Last Name of Student,

\_\_\_\_\_  
First Name

## MEDICAL MATTERS (Emergency Form)

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes:**

**1. Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event 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 NUMBER: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**2. Other Medical Treatment:** In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of San Diego, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as a headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**3. Medications:** My child is taking medication 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 follow:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**4.** No medication of any type whether prescription or nonprescription may be ministered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**5.** I hereby grant permission for nonprescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child if deemed advisable.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Special Medical Information:** The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, insects, etc.): Yes \_\_\_\_\_ Name(s): \_\_\_\_\_ No \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does student have a medically prescribed diet? Yes \_\_\_\_\_ No \_\_\_\_\_

Any physical limitations? Yes \_\_\_\_\_ No \_\_\_\_\_

Is student subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? Yes \_\_\_\_\_ No \_\_\_\_\_

Has student recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, date and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what are those conditions: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

