

MEDICAL RELEASE FORM

PARTICIPANT'S NAME: _____ BIRTHDATE: _____ SEX: _____

FAMILY DOCTOR: _____ PHONE: (____) _____

Family Health Plan Carrier: _____ Policy Number: _____

MEDICAL MATTERS: I hereby warrant 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.

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 of an emergency, if you are unable to reach me at the above numbers, contact:

NAME & RELATIONSHIP: _____

HOME PHONE: (____) _____ BUSINESS PHONE: (____) _____

Signature _____ Date _____

Other Medical Treatment: In the event it comes to the attention of DESIGNATED SUPERVISOR or staff that SON/DAUGHTER/WARD becomes ill with symptoms of headache, vomiting, sore throat, fever, or diarrhea, I DO want to be called collect (with phone charges reversed to myself if necessary).

Medications: SON/DAUGHTER/WARD is taking medications at present and will bring all such medications necessary, and such medications will be well labeled. I give permission for SON/DAUGHTER/WARD TO TAKE THIS MEDICATION ON HIS/HER OWN. The dosage and frequency of dosage is as follows:

Signature _____ Date _____

If requested, I DO give permission for SON/DAUGHTER/WARD to be given the following (circle):

Aspirin	Benedryl	Midol	Ibuprofen	Pepto Bismo	Cough drops
Aspicream	Tums	Sudafed	Primatene Mist	Tylenol	Other _____

Signature _____ Date _____

No Medication of Any Type: whether prescription or nonprescription may be administered to my SON/DAUGHTER/WARD unless the situation is life threatening and emergency treatment is required.
Signature _____ Date _____

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations?

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps measles, chickenpox, etc.?

If so date and disease or condition: _____

You should be aware to these special medical conditions of my child: _____
