

MEDICAL INFORMATION FORM

This Medical Information Form should be completed annually. **It is the responsibility of the parent/guardian to inform the school or parish of any changes in the child's medical condition during the year.**

Participant: _____

Parent/Guardian: _____ **Phone:** _____

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

Emergency contact name (please print): _____

Relationship to participant: _____

Cell Phone: _____ Other Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

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. YES _____ NO _____

Other Medical Treatment: In the event it comes to the attention of the parish/school/institution, its officers, directors and agents, and the Archdiocese of Mobile, 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. YES _____ NO _____

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.

YES _____ NO _____

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

YES _____ NO _____

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

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 follows:

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

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

If yes, what is it? _____

Does child have any physical or other limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, flu, etc.? _____ If yes, list date and disease or condition: _____

Additional special medical conditions of my child: _____

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.

Parent/Guardian Signature _____ Date _____