Youth Medical Consent and Permission to Treat

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 that are applicable*.

Insurance Information:
Family Health Plan Carrier: _____ Policy Number: _____

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.
Signature of Parent/Guardian:_____ Date:_____

In the event of an emergency, *if you are unable to reach me*, contact:
Name: _____ Relationship: _____
Phone:( ) _____ My son/daughter is under the care of a medical provider. ___Yes ___No
Provider Name: _____Phone Number: ( )_____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the *Parish Visitors of Mary Immaculate*, chaperons, 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. **Signature: _____ Date: _____**

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:
_____
_____
_____ **Signature: _____Date: _____**
I give permission for my child to self-administer over-the-counter medication such as Tylenol, Benadryl, Ibuprofen during their participation in this event. **_____ Initials of parent/guardian.**

Specific Medical Information: We 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? _____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: _____
You should be aware of these special medical conditions of my child:
_____