

MEDICAL RELEASE FORM

PARTICIPANTS NAME _____ BIRTH DATE _____ SEX : M F
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 farther treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above number, contact:

NAME & REALTIONSHIP: _____
HOME PHONE (____) _____ BUSINESS PHONE (____) _____
Signature _____ Date _____

OTHER MEDICAL TREATMENT

In the event it comes to the attention of the DESIGNATED SUPERVISOR or staff that my 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)

Signature _____ Date _____

MEDICATIONS

My 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 my 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 my SON/DAUGHTER/WARD to be given the following (please circle)

Asprin Benedryl Midol Ibuprofen Pepto Bismo Cough Drops
Tums Aspicream Sudafed Primatene Mist Tylenol Other _____

Signature _____ Date _____

NO MEDICATION OF ANY TYPE

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 _____

SPECIAL MEDICAL INFORMATION

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

Allergic Reactions (medicine, food, plants, insects, etc.): _____
Immunizations: Date of last tetanus/diphtheria immunization: _____
Does child have a medically prescribed diet? _____
Any physical limitations? _____
Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____
Has child recently been exposed to a contagious disease (ex. Mumps, measles, chicken pox, etc.) If so, please list date and disease _____
You should be aware to these special medical conditions of my child _____