Medical Information Form

(Completed one time per year, on file at School/Parish)

I. Participant's First name: _____ Last Name: _____

Date of birth: _____

Parent/Guardian's First Name: _____ Last Name: _____

Home Address: _____

Home phone number: _____

Parent/Guardian cell phone number: _____

Medical Matter: 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.~

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: _____

Phone: _____ Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

Medications: My child is taking medication at present and may have to take the Medication while on a School related activity. 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: _____

II. Other Medical treatment and Information

(Completed one time per year and kept on file at the School)

YES	NO	
☐	☐	No Medications of any type, prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.
☐	☐	I grant permission for non-prescription medication (acetaminophen, ibuprofen, throat lozenges, cough syrup…) to be given to my child if deemed appropriate by staff members and chaperones.
☐	☐	My child has allergies. Specifically allergic to:
☐	☐	My child is on a medically prescribed diet. Describe:
☐	☐	My child has physical limitations. Describe:
☐	☐	You should be aware of the special medical needs of my child. Describe:

Date: _____ Signature of Parent or Guardian: _____

Photographs and videos: Parents/guardians of participants are advised that photographs or videotapes of participants may be used in publications, websites or other materials produced periodically by the Diocese of Boise or local parishes. (Participants would not be identified without specific consent. Parents/guardians who do not wish their child (ren) to be photographed or filmed should notify the Parish/Diocese of Boise in writing. Please note that the Diocese of Boise has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate.