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:
_____
_____

Appendix 2

MEDICAL INFORMATION FORM
(Continued)

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.? Yes ◯ No ◯ 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 _____

Appendix 2