Office Use:
Date Received _____

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: _____ **Date of Birth:** _____
Parent/Guardian: _____ **Phone:** _____
Address: _____

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: _____

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 _____

MEDICAL INFORMATION FORM
(Continued)

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:

_____

_____

I hereby grant permission for the listed medications to be taken by my child on the trip, if necessary.

Parent/Guardian Signature _____

Other Medical Treatment:

1. I want to be called 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.

Parent/Guardian Signature _____

2. Please read carefully and choose one to sign

   A. 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.

Parent/Guardian Signature _____

OR

   B. 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.

Parent/Guardian Signature _____

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.

Parent/Guardian Signature _____

The school/parish will take reasonable care to see that this information will be held in confidence. At the end of the trip, the duplicate medical form copies must be shredded or returned to the school or parish office by the authorized agent.