

Most Holy Trinity/ Diocese of Galveston-Houston
Medical Consent

Student Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Home Address: _____ City: _____ Zip Code: _____
Parent/Guardian: _____ Hm Phone: () _____
Wk Phone: () _____ Alternate Phone: () _____ cell: Pager:

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 further treatment by the hospital or doctor.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship: _____ Phone: () _____

Family Doctor: _____ Phone: () _____

Medications

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows

My child is taking the following medication at the present time.

Medication(s): _____ Dosage: _____

Administer: _____

_____ I hereby DO NOT GRANT PERMISSION for medication of any type, whether prescription or nonprescription my be administered by my child unless the situation is life threatening and emergency treatment is required. (Please Initial)

_____ I hereby GRANT PERMISSION for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information

(Parish Personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

Has had an episode of the following or been diagnosed: ___ Seizures ___ Asthma ___ Diabetic

Allergic reactions to the following (foods, dyes, latex, etc.) _____

Has had a medical surgery within the last six months? ___yes ___no Still under doctor's care? ___yes ___no

Has a medically prescribed diet? _____

The following physical limitations: _____

Immunizations current and up to date: ___yes ___no Date if last Tetanus/diphtheria immunization _____

You should also be aware of these special medical conditions of my child: _____

Insurance Information

Insurance Carrier: _____

Name of Insured: _____

Insurance ID Number: _____ Insurance Policy Number: _____

Father's Name: _____ Birth Date: _____

Place of Employment: _____

Mother's Name: _____ Birth Date: _____

Place of Employment: _____

_____ No, I do not carry medical insurance at this time.

In the event it comes to the attention of the parish personnel or volunteer teachers or chaperones associated with the program/activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself.)

I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

Signature (Parent/Guardian must sign for anyone under 18 years of age.)

Date

Signature (Participant 18 years or older must sign own consent)

Date

Information will be kept on file for one year. It is the responsibility of parent/guardian to update changes in medical information.