

Name & relationship _____

Phone _____

Family doctor _____

Phone _____

Family Health Plan Carrier _____

Policy # _____

Signature

Date

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Sioux City, 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 collect (with phone charges reversed to myself).

Signature

Date

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: _____

Signature

Date

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.

Signature

Date

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.

Signature

Date

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition _____

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