# PARENT/GUARDIAN MEDICAL INFORMATION & CONSENT FORM

**Diocese of Orlando**

## PARTICIPANT INFORMATION

**Participant's Name:** _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

**Emergency Contact Name:** _____ Phone: _____

Language Spoken by Emergency Contact: _____

## MEDICAL MATTERS

I hereby warrant to the best of my knowledge, all the information provided is true and correct and I assume all responsibility for the health of my child. I understand it is my responsibility to update the Medical Information & Consent Form if there are any changes to my child's health.

*(Please initial)* _____

### Emergency Medical Treatment

In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment.

*(Please initial)* _____

Family Doctor: _____ Phone: _____

### Medications

I hereby **Grant Permission** for my child to be given the following provided medications. All medications must be well labeled. [**NOTE:** Any/all prescription medications must be in original pharmacy container with young person's name on the prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the container.] I release and hold harmless **St. John Vianney Catholic Church**, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication.

*(Please initial)* _____

Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as follows:

Medication: _____ Dosage: _____ Administer: _____

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Medication: _____ Dosage: _____ Administer: _____

**Participant's Name:** _____

## MEDICAL CONDITIONS INFORMATION

*Reasonable steps will be taken to keep this information confidential, but it will be shared with Diocesan personnel and others, as warranted.*

**My son/daughter:**

- Is allergic to the following medications: _____
- Has had an episode of the following or has been diagnosed with: ☐ Seizures ☐ Asthma ☐ Diabetic
- Has had 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 (please explain): _____
- Has the following physical limitations: _____
- Immunizations current and up to date? ☐ Yes ☐ No Date of last tetanus/diphtheria immunization: _____
- You should also be aware of these special medical conditions of my child: _____

  _____

  _____

## INSURANCE INFORMATION

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

Insurance Carrier: _____ Name of Insured: _____

Insurance Policy Number: _____

**In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.**

I fully understand the foregoing statements and sign this Medical Information & Consent Form knowingly, freely, and willingly.

**Parent/Guardian Signature:** _____ Date: _____

*Must sign for any participant under 18 and/or 18 or older and in high school.*