ST. VICTORIA/ST. MICHAEL PARISH FAMILY

MEDICAL MATTERS

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.

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 agree to allow my child to receive emergency medical treatment at my expense at the discretion of the event sponsor. I understand that, should a medical emergency arise, every effort will be made to contact me before such treatment is given. I wish to be advised prior to any further treatment by the hospital or doctor.
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 Archdiocese of Saint Paul & Minneapolis, coaches, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I want to be called collect (with phone charge reversed to myself).

Signature: _____ Date: _____

Medications

Please select all that apply:

My child is *not* taking any medication at present.

My child is taking medication at present. Please list all medications and dosage:
_____

My child will need to take medications during Chillfest hours. (Contact Sara for additional form.)

Signature: _____ Date: _____

Please select only <u>one</u> of the following:

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.

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 (meds, foods, plants, insects, etc): _____

Date of last tetanus/diptheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, H1N1, etc? If so, date and disease or condition: _____

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