

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.**