

**YOUTH MINISTRY MEDICAL RELEASE FORM 2010 - 2011**

Participant's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Parent/Guardian's Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_

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. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

**1. 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 treatments by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_  
BUSINESS PHONE: (\_\_\_\_) \_\_\_\_\_  
FAMILY DOCTOR: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_  
Family Health Plan Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

1). Signature: \_\_\_\_\_ Date: N/A

**2. Other Medical Treatment:** In the event it comes to the attention of the parish, its officers, directors and agents and the Diocese of San Diego, chaperones or representatives associated 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 charged reversed to myself)

2). Signature: \_\_\_\_\_ Date: N/A

**3. 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 child takes such medications, including dosage and frequency of dosage are as follows:

3). Signature: \_\_\_\_\_ Date: N/A

**4. Medications: Choose one of the below listings (A or B):**

A) No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required.

A). Signature: \_\_\_\_\_ Date: N/A

B) I hereby grant permission for nonprescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child if deemed advisable.

B). Signature: \_\_\_\_\_ Date: N/A

**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.): \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

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 diseases or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: \_\_\_\_\_

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