ARCHDIOCESE OF GALVESTON-HOUSTON **MEDICAL CONSENT FORM**

Medical Matters

I hereby warrant 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:

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 and I understand that all financial obligations are my responsibility.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship _____ Phone _____

Family Doctor _____ Phone _____

Medications

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows

My child is taking the following medication at the present time.

Medication(s): _____ Dosage: _____

Administer: _____

_____ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information: (Archdiocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

- Has had an episode of the following or has been diagnosed: ☐Siezures ☐ Asthma Diabetic
- 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?_____
- 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 (e.g. depression, anxiety, etc.):

_____

Insurance Information: ☐**No, I do not carry medical insurance at this time.**

Insurance Carrier:_____ Name of Insured: _____

Insurance Policy Number:_____

Father's Name: _____ Day Phone: _____

Mother's Name: _____ Day Phone: _____

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself). I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____

Signature (Parent/Guardian) Parent/Guardian must sign for anyone under 18 years of age. Date

_____ _____

Signature (Participant 18 years of age or older must sign own consent) Date