IV. Medical Information

(Please check and sign only those below which are in accordance with your wishes; do <u>not</u> sign all sections.)

Select this:

☐ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about his/her care to the parish or school group leaders(s) named here **<u>BLESSED SACRAMENT PARISH & ST. ELIZABETH ANN SETON PARISH DANIEL LAPOLLA</u>**. I wish to be advised prior to further treatment by the hospital or doctor. In the event I cannot be reached, please contact _____ at _____.
Relationship to youth _____.
Family physician _____. Phone _____.

(Please check one of the following)

☐ My son/daughter is covered by hospitalization and medical insurance under policy#_____issued by_____.

☐ My son/daughter does not have medical coverage and I assume responsibility for the cost of hospitalization and medical care for my son/daughter.

Signature: _____ **Date:** _____

Or this:

☐ I hereby warrant that to the best of my knowledge, my son/daughter is in good health. **I do not want any medical treatment to be given to my son/daughter under any circumstances.** I hereby assume all responsibility for the health and well being of my son/daughter and release from responsibility the Bishop of the Diocese of Youngstown, and **<u>BLESSED SACRAMENT PARISH & ST. ELIZABETH ANN SETON PARISH</u>** parish/school, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature: _____ **Date:** _____

Select this:

☐ 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.

Signature: _____ **Date:** _____

Or this:

☐ I hereby grant permission for nonprescription medication (such as acetaminophen, decongestant, cough syrup) to be given to my son/daughter, if requested by my son/daughter and deemed advisable by an adult chaperone.

Signature: _____ **Date:** _____

☐ My son/daughter is taking medications at present. He/she will bring all necessary medications and such medications will be well labeled. The names of and the concise directions for taking such medications, including dosage and frequency of dosage as follows: _____

Signature: _____ **Date:** _____

☐ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, etc.)_____

_____

Signature: _____ **Date:** _____

☐ I would like to have a member of the program staff speak with me further regarding a medical concern or situation. Please contact me at _____.

Return completed form to: _____ **by:** _____