

## Tri-Parish Youth Ministry Medical Release Form

**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. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

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.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative phone: \_\_\_\_\_

**Medications:**

List medications your child is currently taking including dosage and directions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 (Medications, foods, plants, insects, etc) \_\_\_\_\_

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

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 disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: \_\_\_\_\_

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

I understand that the Church will use this medical information for all activities throughout the year and I authorize that in the situation that a change of the above medical information occurs. I will contact the Parish with the changes immediately.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

