Diocese of Stockton

Emergency Health / Medical Information and Consent

In the event of an emergency, I, the undersigned parent/guardian of the child named on this form, hereby gives permission to the Roman Catholic Bishop of Stockton, the Pastor, employees, agents, representatives, Chaperons and adult volunteers (the Designated Person(s)) to arrange for and authorize emergency medical, dental, or surgical treatment for my child, as considered necessary by the attending physician or dentist. I wish to be advised prior to any further postemergency treatment by the hospital, doctor or dentist.

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Family Health Plan Carrier _____

Policy Number _____

I also agree to provide the Pastor, the designated Youth Ministry representatives, Chaperon or adult volunteer with current telephone numbers at which I can be reached, as well as the names and phone numbers of individuals who are likely to know where I am should an emergency arise. In the event of an emergency, if you are unable to reach me at the numbers listed above, please contact: Name ____

Relationship _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

_____ _____

Signature of Parent/Guardian Date

1. If my child becomes ill with symptoms that do not indicate emergency medical treatment (e.g., headache, vomiting, sore throat, fever, diarrhea), I wish to be called collect (reversed phone charges) to be informed of my child's condition.

_____ _____

Signature of Parent/Guardian Date

2. My child is currently taking the following medication(s), which he/she will be bringing on this activity in well-labeled containers that include clear directions for dosage and frequency of usage. I hereby give permission the Designated Person (s) to administer the following medication(s):

_____ _____

Signature of Parent/Guardian Date

Emergency Health / Medical Information and Consent (continued)

3. No medication of any type (prescription or nonprescription) may be administered to my child unless his/her condition is life threatening and emergency treatment is required, as considered necessary by the attending physician.

_____ _____
Signature of Parent/Guardian Date

4. I hereby grant permission for nonprescription medication (e.g., non-aspirin pain relievers, throat lozenges, cough syrup) to be given to my child, if deemed advisable by the Designated Person(s).

_____ _____
Signature of Parent/Guardian Date

Specific Medical Information / Conditions

Allergic reactions (to medications, foods, plants, insects, etc.)

_____

Immunizations (date of last tetanus/diphtheria immunization):

_____

Current medications being taken by child:

_____

Medically-prescribed dietary restrictions?

_____

Physical limitations?

_____

History of severe homesickness, emotional reactions to new situations, sleepwalking, bed wetting, fainting?

_____

Any recent exposure to contagious disease/condition, such as mumps, measles, chicken pox? If so, specify the date and the condition exposed to:

_____

Any other special medical issues to be aware of?

_____