Most Holy Trinity Catholic Church
Diocese of Galveston/Houston
Medical Consent Form

Student Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Home Address: _____ City: _____ Zip Code: _____

Parents/Guardians: _____ _____ Home Phone: _____

Wk Phone: _____ Cell Phone: _____

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:
In the event of any emergency and you are unable to reach me, contact:
Name and 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 take 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 Condition Information

(*Parish 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 been diagnosed: ___ Seizures ___ Asthma ___ Diabetic
Allergic reaction to the following (food, dyes, latex, etc.) _____
Has had a medical surgery within the last six moths? ___ 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: _____

Insurance Information **(**The office will need a copy of your insurance card.)

___ No, I do not carry medical insurance at this time.
Insurance Carrier: _____ Name of Insured: _____
Insurance ID Number: _____ Insurance Policy Number: _____
Father's Name: _____ Birth Date: _____ Place of Employment: _____
Mother's Name: _____ Birth Date: _____ Place of Employment: _____

In the event it comes to the attention of the parish personnel or volunteer teachers or chaperones associated with the program/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 of Parent/Guardian Date