St. Mary's God Squad
519 E. 4th Street
Alton, IL 62002
618-465-4284

MEDICAL MATTERS

Name: _____

Address: _____

City, State, Zip: _____

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.)

1. 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. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Father/Guardian: _____ Cell Phone: _____

Mother/Guardian: _____ Cell Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

2. Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Springfield in Illinois, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be contacted immediately.

Signature: _____ Date: _____

3a. Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

_____

_____

Signature: _____ Date: _____

Please choose only one option from the following choices:

3b. I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, Benadryl, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

OR

3c. No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

4. 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 immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

_____

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

_____

_____

Signature: _____ Date: