Name & relationship: _____

Phone: _____ Family doctor _____ Phone: _____

Family Health Plan Carrier: _____ Policy #_____

Signature: _____ Date _____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Lexington, chaperones, 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 called.
Signature _____ Date _____

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 is as follows:

_____
_____

Signature: _____ Date _____

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

I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as 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.

Allergies (medications, foods, plants, insects, etc.)

_____

Immunizations: Date of last tetanus/diphtheria immunization:

_____

Does your 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.? List date and disease or condition:

_____

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

_____

_____