FORM 2 – MEDICAL INFORMATION & RELEASE

Catholic Diocese of Shreveport and/or the Church of _____

Participant's name: _____ **Age:** _____ **Date of Birth:** _____

Participant is a: ☐ Youth ☐ Young Adult (18-20) ☐ Adult Chaperone (21 or older)

Is the participant medically insured? Choose One

If the participant is medically insured, please attach a copy of the medical insurance card (front and back) to this document.

Specific Medical Information (Feel free to attach additional sheets with notes if the spaces below do not suffice.)

1. You should be aware of these special medical conditions and/or needs (e.g. physical, developmental, behavioral, cognitive, or other diseases, disabilities, disorders or limitations): _____
   _____
   _____ (Continue on back if needed)

2. Allergic reactions (medications, foods, plants, insects, latex, etc.): _____
   _____ (Continue on back if needed)

Medications (This section pertains to **youth only**. We do not need this information for adults. ONLY check boxes that apply):

☐ This child takes no medication and will bring no medication with him/her.

☐ This child takes medication/s and will self-medicate. All medications will be clearly labeled. The child will be required to surrender all medication(s) to a designated adult. It will be this child's responsibility to appear at the designated location and times listed below to obtain the medications. At the conclusion of the event, it will be this child's responsibility to retrieve remaining medication(s) from the designated adult. Names of medications and exact dosage and frequencies/times are as listed below: (Attach a sheet to this form if you need more space.): _____
_____ (Continue on back if needed)

☐ This child takes medication but shall not self-medicate. The parent/guardian will provide and dispense medications.

☐ The following nonprescription medications may be given in the recommended dosage on the medication bottle.

Non-aspirin pain reliever:	Choose	Antacid:	Choose
Throat Lozenge:	Choose	Antihistamine:	Choose
Decongestant:	Choose		

In case of an emergency and for permission for treatment of the participant beyond emergency procedures, please contact:

Name: _____ Relationship to participant: _____

Cell Phone #: _____ Other Phone Number: _____

By signing below, I, _____ confirm that, to the best of my knowledge, I or the above named child
(Parent, Guardian or Adult Participant's Name)
am/is in good health and I take full responsibility for my or the above named child's health. I confirm that the Diocese of Shreveport and/or the church listed above has my full and complete permission to seek and obtain medical attention for myself or the above named child in the event of any accident or illness which may occur, including the authorization to consent to emergency medical care, if required during any diocesan or church events between the dates _____ **&** _____. I understand that reasonable efforts will be made to advise parents, guardians or emergency contacts of my or the above named child's condition prior to any treatment.

I acknowledge and agree that it is my responsibility to inform the Diocese of Shreveport and or the church listed above if at any time any of the above information needs to be changed, amended, or updated prior to the expiration date of this Medical Consent. I also confirm that to the best of my ability, I have not omitted any pertinent information, everything I have stated herein is true, and accurately reflects my wishes.

Adult or Parent/Guardian Signature _____ **Date** _____

Adult or Parent/Guardian Phone number: _____

FORM 2 – MEDICAL INFORMATION & RELEASE

Continuation of Specific Medical Information

1. Special medical conditions or needs:

2. Allergic reactions: