MEDICAL INFORMATION & CONSENT FORM

Activity: Hands for Hoyleton Mission Trip Date: June 10-13, 2022
Parish: St. Clare_____ Town: O'Fallon, IL _____

Participant's Name: _____ Birth Date (mm/dd/yy): _____

Parent/Guardian Name(s): _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

MEDICAL INFORMATION:

1. Does the participant take medication regularly? ☐ Yes ☐ No
   If yes, describe: _____

2. Does the participant have any allergies or chronic illnesses? ☐ Yes ☐ No
   If yes, describe: _____

3. Is the participant allergic to any drugs or medications? ☐ Yes ☐ No
   If yes, describe: _____

EMERGENCY MEDICAL TREATMENT*:** *In the event of an emergency, I hereby give permission to transport my child to a hospital and for emergency medical or surgical treatment. I also give permission for health officials to release medical information on my child Karen Jalbert, the St. Clare Youth Group leader, or other designated staff. 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:*

Name & relationship: _____

Phone: _____ Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ **Date**: _____

☐ Yes , I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

☐ No, I **do not** grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ **Date**: _____

ACKNOWLEDGEMENT & CONSENT:

I/We have read the above form. I/We fully understand the agreement and consent to its terms.

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____