STUDENT MEDICAL RELEASE
CHURCH OF ST. JOHN
FOLEY, MN

Parent/Guardian _____ Relationship _____

Home phone _____ Work _____ Cell _____

_____ Relationship _____

Home phone _____ Work _____ Cell _____

Names of Children _____ _____

_____ _____

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. **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, **please contact:**

Name _____ Relationship _____

Home phone _____ Work phone _____ Cell _____

Parent/Guardian Signature _____ Date _____

Of the following statements, **initial only those that are applicable.**

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of St. Cloud, 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 (collect, if necessary, with phone charges reversed to myself).

Parent/Guardian Initial _____ 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, are as follows: **Please list on reverse side with child's name.**

Parent/Guardian Initial _____ Date _____

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.

Parent/Guardian Initial _____ Date _____

OVER

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

Parent/Guardian Initial _____ Date _____

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)

Name of child _____

Immunizations are current? Yes _____ No _____

Does you child have a medically prescribed diet? Please explain.

Name of child _____

Please be aware of the following special medical conditions of my child.

Name of child _____

Name of child _____

Important information:

Family Health Care Plan Carrier _____ Policy # _____

Phone number _____

List any medications and/or supplements (with dosage) the participant is currently taking including OTC (Over The Counter).

Name of child _____

Name of child _____

Name of child _____

List any injuries and/or illnesses recently sustained and the necessary recommendations.

Name of child _____

Name of child _____

Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____ Cell _____