MEDICAL MATTERS

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 apply.

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 phone numbers, contact:

Name and 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 school, its administrators, officers and agents, and the Diocese of Covington 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 (at my expense, if applicable).

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, are as follows:

_____

_____

Signature _____ 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.

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 school 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? ☐ Yes ☐ No _____

Any physical limitations: ☐ Yes ☐ No _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? ☐ Yes ☐ No

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? ☐ Yes ☐ No

If Yes, provide date and disease or condition _____

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

_____

_____

_____