



Medical Release Form

Mission 3:16 Youth Ministry

TEENS NAME _____ PARENT/GUARDIAN NAME _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment: In the event of any 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 even of any emergency, if you are unable to reach me at the above numbers, contact:

NAME & RELATIONSHIP: _____ Phone: () _____

FAMILY DOCTOR: _____ Phone: () _____

Family Health Plan Carrier: _____

Policy Number: _____

1.) 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 San Diego, 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 (with phone charged reversed to myself).

2.) 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:

3.) Signature: _____ Date: _____

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

4.) Signature: _____ Date: _____

I hereby grant permission for nonprescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

5.) Signature: _____ 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.) _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does 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 been exposed to contagious disease conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: _____

You should be award of these special conditions of my child: _____
