

ARCHDIOCESE OF NEW ORLEANS  
MEDICAL INFORMATION AND CONSENT FORM

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**GENERAL INSTRUCTIONS TO PARENTS/GUARDIANS:**

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
  2. Sections I, II and V are mandatory. Sections III and IV provide you with treatment options in non-emergency situations.
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Participant's name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent/Guardian's name \_\_\_\_\_

Home address: \_\_\_\_\_  
(Street) (City/State) (Zip)

Home phone: \_\_\_\_\_ Cellular phone: \_\_\_\_\_

Business phone: \_\_\_\_\_ Other: \_\_\_\_\_

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**SECTION I. MEDICAL MATTERS**

As the parent/legal guardian of the above named child, who is currently associated with \_\_\_\_\_ Parish. I hereby authorize \_\_\_\_\_ or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from \_\_\_\_\_, 200\_ through \_\_\_\_\_, 200\_. 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.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**SECTION II. 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 numbers listed herein, contact:

Name & relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SECTION III: OTHER MEDICAL TREATMENT

In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of New Orleans, 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 charges reversed to myself).

Signature \_\_\_\_\_ Date: \_\_\_\_\_

SECTION IV: MEDICATIONS

*(SIGN ONLY THOSE OPTIONS THAT ARE APPLICABLE)*

- 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: \_\_\_\_\_

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

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: \_\_\_\_\_

SECTION V: 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, bed-wetting, fainting? \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? \_\_\_\_\_ If so, date and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child: \_\_\_\_\_  
\_\_\_\_\_