

*St. Mary's*  
519 B. 4<sup>th</sup> Street  
Alton, IL 62002  
618.465.4284



*Ss. Peter and Paul*  
717 State Street  
Alton, IL 62002  
618.465.4221

**MEDICAL MATTERS**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

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 are applicable.)**

***1. 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, contact:

Father/Guardian: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

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

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

***2. Other Medical Treatment:*** In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Springfield in Illinois, chaperons, 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 contacted immediately.

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

***3a. 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:

\_\_\_\_\_  
\_\_\_\_\_

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

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

***Please choose only one option from the following choices:***

3b. I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, Benadryl, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

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

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

***OR***

3c. 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: \_\_\_\_\_

***4. 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? \_\_\_\_\_

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

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

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