Diocese of Belleville
Office of Education

MEDICAL INFORMATION AND CONSENT FORM

School Name and City_____

Participant's Name_____ Birth Date_____

Parent/Guardian Name_____

Address_____

City/State/Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Emergency Contact (*if parent/guardian cannot be reached*):

Name_____ Phone_____

Physician's Name_____ Phone_____

MEDICAL INFORMATION

1. Does the participant take medications regularly? _____Yes _____No
   If yes, describe:_____
2. Does the participant have any allergies or chronic illnesses? _____Yes _____No
   If yes, describe:_____
3. Is the participant allergic to any drugs or medications? _____Yes _____No
   If yes, describe:_____
4. Is the participant covered by medical insurance? _____Yes _____No
   If yes, describe:_____

In the event that my child,_____ requires emergency medical treatment due to illness or injury, I hereby give my consent to the following:

1. personnel supervising my child arrange for emergency medical care at an appropriate facility;
2. medical personnel at the medical facility to render necessary treatment to my child.

I further acknowledge and agree that I will assume responsibility for payment of all expenses associated with the medical care above described.

Parent/Guardian_____

Date_____