Diocese of St. Augustine
Parent / Guardian Medical Release

Child's Name: _____ Date of Birth: _____

Parent / Guardian Name: _____

Home Address: _____ Home Phone: _____

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 in accordance with your wishes.)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to Diocese of St. Augustine's employees, volunteers, or representatives to seek medical treatment for my child above named.

If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Diocesan representatives or volunteers to hospitalize, secure proper treatment for, and to order injection and / or anesthesia and / or surgery for my child above named.

In the event of an emergency, if you are unable to reach me at the above number, contact:

Name and Relationship: _____ Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy Number: _____

I make the following exception: _____

_____

My Child's Medications / Dosages: _____

Medication: _____ Dosage: _____ Doctor: _____

Medical Problem or Condition (allergies, diabetes): _____

Condition: _____ Symptoms: _____

Physical Disabilities: _____

_____ _____
Signature of Parent / Guardian Date

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the Diocese of St. Augustine's employees, volunteers, or representatives that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

_____ _____
Signature of Parent / Guardian Date

(Side B)