

Diocese of Belleville
 Youth Ministry
 Medical Information & Consent Form

Participant's Name:	Date of Birth:
Parent/Guardian Name:	
Address:	
Home Phone Number:	Work Phone Number:
Emergency Phone Number:	

1. Does the participant take medications regularly? YES NO
 a. If yes, please describe _____
2. Does the participant have any allergies or chronic illnesses? YES NO
 a. If yes, please describe _____
3. Is the participant allergic to any drugs or medications? YES NO
 a. If yes, please describe _____

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:

Name & Relationship:	Phone:
Family Doctor's Name:	Doctor's Phone:
Name of Health Insurance:	Policy Number:

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

Signature for Non-Prescription Medication **Date**

I/We have read the above form. I/We fully understand the Agreement and Consent to its terms.

Parent/Guardian **Date**

Parent/Guardian **Date**