Quest - Northeast Nebraska

Medical Matters

Youth Participant Name: _____ 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.)**

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.

Parent(s) Name: _____Phone:_____

Alternate Phone:_____Family doctor:_____Phone: _____

Family Health Plan Carrier: _____Policy #**:** _____

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

Name & relationship: _____

Phone:_____

Signature:_____Date:_____

Other Medical Treatment: (In the event it comes to the attention of the parish/school, its officers, directors and agents, and the Archdiocese of Omaha, 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 reverse to myself),

Signature: _____Date:_____

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:

Signature: _____Date:_____

Sign 'a' or 'b', not both

a) 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:_____

b) 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:_____

Specific Medical Information: The parish/school/Archdiocese 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 the child have a medically prescribed diet?_____

Any physical limitations?_____

Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?_____

Has the 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: