

MEDICAL RELEASE
2011-2012

FAMILY Last Name _____ Parents/Guardians _____

Children's Names _____

Home Phone # _____ Cell Phone # _____

Family Doctor _____ Phone # _____

Family Health Plan Carrier _____ Policy Number _____

Medical Matters: I hereby warrant that to the best of my knowledge, my child(ren) is/are in good health, and I assume all responsibility for the health of my child(ren).

(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 Our Lady of Good Counsel Roman Catholic Church's employees, volunteers, or representatives to seek medical treatment for my child(ren) named above. In the event of an emergency, I hereby give permission to the physician selected by (either: the above named Diocesan entity's representatives or Our Lady of Good Counsel) or volunteers to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child(ren) named above. If you are unable to reach me, please contact my emergency contact, listed on my family's registration form.

I make the following exception: _____

Printed Name of Parent/Guardian who is signing this release form: _____

Signature of Parent/Guardian _____ **Date signed** _____

OTHER MEDICAL TREATMENT: In the event it comes to OLGC staff's attention that my child(ren) becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea – I hereby give permission to Our Lady of Good Counsel Roman Catholic Church's employees, volunteers, or representatives for over-the-counter medication to be administered to my child(ren) according to directions.

Printed Name of Parent/Guardian who is signing this release form: _____

Signature of Parent/Guardian _____ **Date signed** _____

Please list below **allergies or Health issues:**

My child(ren)'s medications/conditions:

Child's Name: _____

Medication _____ Dosage _____ Prescribing Physician _____

Medication _____ Dosage _____ Prescribing Physician _____

Medical Problem/Condition _____ Symptoms _____

Child's Name: _____

Medication _____ Dosage _____ Prescribing Physician _____

Medication _____ Dosage _____ Prescribing Physician _____

Medical Problem/Condition _____ Symptoms _____