

MEDICAL RELEASE AND CONSENT FORM

PARENT

I, _____; the undersigned, give my permission for my son/daughter _____ and if needed, to be evaluated, diagnosed, treated and/or medicated in accordance with standard medical practice by licensed medical personnel. I relieve the Diocese of Fall River and St. Francis Xavier Church of all responsibility and consequences that may arise as the result of this treatment.

I will not hold St. Francis Xavier, the Youth Directors nor the Diocese, chaperones, or representatives associated with the youth event responsible in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling such treatment.

I understand that St. Francis Xavier and the Youth Directors nor the Diocese will be held liable if my child fails to cooperate with said regulations and that any infractions of the rules may result in immediate prevention from future outings. I will be responsible for any costs or other requirements for immediate transportation home.

MEDICAL INFORMATION (please print)

My child is allergic to _____

My child must take the following medication (indicate dosage, frequency etc.) _____

Doctor's Name _____ Phone _____
Insurance Carrier _____ Policy Carrier _____
In case of emergency notify _____
Home Phone _____ Emergency Phone _____
Relationship to Youth _____

SIGNATURE:

Parent/Guardian _____ Date _____

- My child has permission to medicate him/her self as needed.*
- I want a chaperone to dispense the medication for my child.*
- A chaperone has permission to dispense Tylenol if needed.*

Photo copy of Health Insurance Card [Hospital Requirement] Medical facilities will not treat without such document.

➤ *Please attach photo of medical insurance card here.*