

Cathedral of the Immaculate Conception

Name of Parish

MEDICAL CONSENT TO TREAT

To the best of my knowledge, my child, _____, is in good health, and I assume all responsibility for the health of my child. In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

My Child's... Age: _____ Height: _____ Weight: _____

I hereby grant permission for non-prescription medicine (such as cough drops, cough syrup, Tylenol, etc.) to be given to my child as necessary. I understand that aspirin will not be given to my child.

If you are unable to reach me, please contact:

Name Relationship to My Son/Daughter Telephone Number with Area Code

Please attach a photocopy of your Insurance Card (front & back)!

Insurance Carrier Policy Number Insurance ID Number

Please fill in the following as it pertains to your child:

My son/daughter is taking medication and will bring all medication with him/her and it will be clearly labeled. My son/daughter is taking the following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows: _____

My son/daughter is allergic to the following: _____

My son's/daughter's immunizations are current and up-to-date: Yes No

My son/daughter has the following limitations: _____

My son/daughter has special needs which are: _____

Signature of Parent/Guardian Date