Youth Ministry

UNIVERSAL MEDICAL FORM & UNIVERSAL PERMISSION SLIP

Student/Participant's Name: _____

(H)Phone: _____ Age: _____ D.O.B.:____ /____ /____ Sex:_____

Home Address: _____

City: _____ Zip: _____ Grade Level and School: _____

Email: _____

Mother's Name: _____ Phone: (Daytime) _____ (Cell) _____

Father's Name: _____ Phone: (Daytime) _____ (Cell) _____

Doctor's Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Medications my child is currently taking: _____

Allergies, disorders, disabilities, or other medical conditions (please specify): _____

_____

Insurance Company and name of Policy Holder: _____

Health Plan Carrier Idea #: _____ Plan #: _____

Names and Phone Numbers of 2 Emergency Contact Persons if Parents/Guardians cannot be reached:

1) Name and Relation to Participant: _____ Phone:_____

2) Name and Relation to Participant: _____ Phone: _____

I, _____ (Parent or Guardian Name), grant permission for _____ (Child Name) to participate in the YOUTH MINISTRY PROGRAM sponsored by St. Jude of the Lake parish and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify St. Jude of the Lake parish and the Archdiocese of St. Paul & Minneapolis from any claims or law suits brought against St. Jude of the Lake parish /Archdiocese of St. Paul & Minneapolis by myself, my child or others, that arise out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the St. Jude of the Lake parish and the Archdiocese in defense of such a claim/suit. In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached I hereby give St. Jude of the Lake parish the permission to act in my behalf in seeking emergency treatment for my child in the event that such treatment is deemed necessary by St. Jude of the Lake. I give my permission to those administering emergency treatment to do so, using those measures deemed necessary. I absolve St. Jude of the Lake parish from liability in acting on my behalf in this regard so long as St. Jude of the Lake is not grossly negligent.

I UNDERSTAND IF THERE ARE ANY CHANGES DURING THE YEAR, IT IS THE RESPONSIBILITY OF THE PARENT(S) OR YOUTH TO UPDATE THIS INFORMATION WITH ST. JUDE OF THE LAKE YOUTH MINISTRY.

I have read, understand, and agree to the statement above.

_____ _____

Parent/Guardian Signature Date

HEALTH INFORMATION:

For headache or minor pain, my child may be given: _____

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital. I agree to allow my child to receive emergency medical treatment at my expense at the discretion of the event sponsor. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact:

_____ _____ _____

MEDICAL MATTERS: 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*.)

Medical Treatment: In the event it comes to the attention of ***St. Jude of the Lake*****,** other participating parishes, and the Archdiocese of St. Paul & Minneapolis from, chaperons, 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 at my expense.

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 **indicated on attached Prescription Drug & Medical Authorization Form**.

Signature: _____ Date: _____

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

Signature: _____ Date: _____

Specific Medical Information: ***St. Jude of the Lake*** and other participating parishes 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 child have a medically prescribed diet? _____

Any physical limitations? _____

Has 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:

_____