2018
St. Francis of Assisi
High School Faith Formation
Medical Information
Form must be completed annually for daughter/son to participate.

MEDICAL INFORMATION for 2018 Summer Mission Trip

First name:_____MI _____Last name: _____

Address _____
(street, city, state and zip)

Legal Guardians' Name: _____

Parent cell phone number: _____

Best E-mail to communicate with: _____

Home Phone_____ Emergency Phone _____

INSURANCE INFORMATION:

Policy Holder's Name: _____

Insurance Company Name: _____

Policy/Subscriber Number: _____

HEALTH/MEDICAL INFORMATION:

☐	Allergic reactions (medications, foods, plants, insects, etc.)
☐	Immunizations: Date of last tetanus/diphtheria immunization:
☐	Any physical limitations:
☐	Is daughter/son subject to chronic homesickness, fainting, emotional reactions to new situations, sleepwalking, bed-wetting, etc.?
☐	Has daughter/son recently been exposed to a contagious disease or condition, such as mumps, measles, chicken pox, etc.? If so, please give date and disease or condition:

☐	My daughter/son 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 my child takes such medications, including dosage and frequency of dosage, are as follows: ☐ I further consent to my child self administering her/his own medications. **OR** ☐ I request an adult in charge to dispense my child's medications and I understand that such adult may have no medical training.
☐	I hereby grant permission for nonprescription medication (such as aspirin, Tylenol, lozenges, cough syrup) to be given to my daughter/son, if deemed advisable.
☐	Medically prescribed dietary needs:
☐	Additional special medical conditions of daughter/son

I hereby consent in case of injury or illness, to have the Parish staff or adults in charge of applicable activity obtain necessary medical assistance and/or treatment for qualified medical personnel for my son/daughter_____.in the event that I cannot be reached.

I further give permission to the physician selected to render medical treatment deemed necessary and appropriate by that physician.

I agree to be financially responsible for the cost of such assistance and/or treatment and understand that my insurance shall be primary for such costs.

Legal Guardian Signature _____ Date _____