# DIOCESE OF BELLEVILLE OFFICE OF YOUTH MINISTRY
# MEDICAL INFORMATION & CONSENT FORM

Participant's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

Address: _____

Two Contact Numbers: _____ & _____

**MEDICAL INFORMATION:**

1. Does the participant take medications regularly? _____ Yes _____ No

   If yes, describe: _____

2. Does the participant have any allergies or chronic illnesses? _____ Yes _____ No

   If yes, describe: _____

3. Is the participant allergic to any drugs, medications, food, etc.? _____ Yes _____ No

   If yes, describe: _____

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*Emergency Medical Treatment:* In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: _____ Contact Number: _____

Family Doctor: _____ Doctor Contact Number: _____

Health Insurance Provider: _____ Policy/Group#: _____

I hereby agree grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup, etc.) to be given to my child if deemed appropriate.

Signature: _____ Date: _____

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I/We have read the above form. I/We fully understand the agreement and consent to its terms.

Parent/Guardian Signature: _____ Date: _____

Parish: **St. Mary Catholic Church of Anna, IL** Event: _____