Diocese of Great Falls-Billings

Events, Travel, and Permission Policy

Student Medical Information

☐ **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 any 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 to Youth:	**Phone**
Family Doctor:	**Phone**
Family Health Plan Carrier:	**Policy Number**

☐ **Other Medical Treatment:**

In the event it comes to the attention of the parish, school, or Diocese of Great Falls-Billings, their officers, directors, agents, chaperones, 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.

☐ **Medications:**

My child is taking medications at present. My child will bring all such medications necessary and such medications will be well-labeled. *All prescription medication will be in original prescription packaging.* Names of all medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are attached to this document.

☐ **No Medication:**

No medication of any type whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

☐ **Non-Prescription Medication:**

I hereby grant permission for non-prescription medication to be given to my child, if deemed appropriate.

Parent/Guardian Signature **Date**

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Specific Medical Information:

The following information will be held in confidence and
will only be shared for the safety and wellbeing of your child.

Youth/Participant:	
Allergic reactions (medications, foods, plants, insects, etc.):	
Physical limitations:	
Does your child have a medically prescribed diet? If so, please describe:	
Has your child recently been exposed to any contagious disease or conditions? If so, please list date of exposure and disease or condition:	
Date of last tetanus/diphtheria immunization:	
Is your child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?	
Please list any other special medical conditions your child may have:	
Parent/Guardian Signature	**Date**