

**Diocese of St. Augustine**  
**Parent / Guardian Medical Release**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**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 in accordance with your wishes.)

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I hereby give permission to Diocese of St. Augustine's employees, volunteers, or representatives to seek medical treatment for my child above named.

If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Diocesan representatives or volunteers to hospitalize, secure proper treatment for, and to order injection and / or anesthesia and / or surgery for my child above named.

In the event of an emergency, if you are unable to reach me at the above number, contact:

Name and Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I make the following exception: \_\_\_\_\_

My Child's Medications / Dosages: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Doctor: \_\_\_\_\_

Medical Problem or Condition (allergies, diabetes): \_\_\_\_\_

Condition: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Physical Disabilities: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**OTHER MEDICAL TREATMENT:** In the event it comes to the attention of the Diocese of St. Augustine's employees, volunteers, or representatives that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**(Side B)**