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Medical Information

We hereby warrant that to the best of our knowledge, our child is in good health, and we assume all responsibility of our child.

Emergency Medical Treatment: In the event of an emergency, we hereby give permission to chaperones, representatives, agents, volunteers, and employees of the Archdiocese of Kansas City in Kansas, St. James Academy of Lenexa, Kansas, and others selected by the adult chaperones at their discretion, to transport my son/daughter to a hospital for emergency medical or surgical treatment. We hereby authorize the treatment, administration of anesthesia, and surgical treatment(s) for our son/daughter in the event of a medical situation during our absence or when the hospital or physician(s) are unable to contact us. This authorization extends to any hospital, physician(s) and nursing personnel within the physician's staff where treatment is rendered. We release from medical responsibility and liability the hospital, physician(s) and nursing personnel for performing medical procedures acting on the authority of this medical treatment consent form, which such medical providers deem necessary for our son/daughter.

Student's Name: _________________________________

Mother's Name: ____________________________ Cell: ____________________________

Father’s Name: ____________________________ Cell: ____________________________

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

Person to contact in case of emergency: ________________________________

Phone #’s (both work and home): ________________________________

Family Physician: ________________________________

Phone # of Family Physician: ________________________________

__________________________  ______________________________
Medical Insurance Company  Insurance Policy Number

__________________________
Phone Number

__________________________  ______________________
Signature of Parent or Guardian  Date

__________________________  ______________________
Signature of Parent or Guardian  Date

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**Medical Information**

Medications: Our son/daughter is taking medications at present. Our son/daughter will bring all such medications necessary and such medications will be well labeled. Names of medications and concise directions, including dosage and frequency of dosage are as follows:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Specific Medical Information: Please provide the following information concerning your child's heath. Allergic reactions (medications, foods, plants insect bites, etc.)

_______________________________________________________________________________

_______________________________________________________________________________

Immunizations: Date of last Tetanus/Diphtheria immunization: _________________________

Has your son/daughter recently been exposed to contagious disease or condition, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition:

_______________________________________________________________________________

_______________________________________________________________________________

Does your son/daughter have a medically prescribed diet? ____________________________

_______________________________________________________________________________

Any physical limitations? ______________________________________________________

Is your son/daughter subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?

_______________________________________________________________________________

If yes, what are tools that have been successful if the specified situation above should arise?

_______________________________________________________________________________

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Are there any concerns with traveling this far away from home? Any history of anxiety when placed in new environments?

________________________________________________________________________________

Does your son/daughter have a history of anxiety or depression? ____________________________

If yes, are there concerns directly regarding this trip?

________________________________________________________________________________

________________________________________________________________________________

Other special medical conditions we need to be aware of:

________________________________________________________________________________

Medications: Students will be responsible for bringing their own medication. This includes ALL prescription and over the counter medications.

Please attach the following on one piece of paper to this form;
   A copy of your son/daughter's insurance card
   List of all medications
   List of allergies
   List of medical conditions
Students will carry this on their person.

Parent's Signature ____________________________ Date ____________________________

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