

**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 Marywood Retreat Center's employees, volunteers, or representatives to seek medical treatment for my child above named.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Marywood Center's 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 Marywood Center 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