Shrine of St. Padre Pio Catholic Church
MEDICAL CONSENT AND PERMISSION TO TREAT

My child is in the care of Shrine of St. Padre Pio Catholic Church for the purpose of this parish activity:
_High School Youth Group Spring Retreat_____

I am giving medical permission and consent to treat.
To the best of my knowledge, my child, _____
is in good health, and I assume all responsibility for the health of my child.

In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

Parent/Guardian's Name: _____
Home Address: _____Zip: _____
Home Phone: _____Cell Phone: _____

If you are unable to reach me, please contact:

Name: _____
Relationship to me or my son/daughter: _____
Home Phone: _____Cell Phone: _____

Please include a photocopy of your Insurance card, front and back. ONLY IF NOT ON FILE
Insurance Carrier: _____ Policy Number: _____
My son/daughter is taking medication and will bring all medication with him/her and it will be clearly labeled.
My son/daughter is taking the following medications and directions for taking this medication, including dosage, frequency and storage are as follows:_____
_____
_____
I hereby grant permission for non-prescription medications (such as cough drops, cough syrup, Tylenol etc.) to be given to my child if necessary. I understand that aspirin will not be given to my son/daughter without my express permission. I grant such permission _____Yes, _____No.

My son/daughter is allergic to the following: _____
My Son/daughter's immunizations are current and up to date _____Yes, _____No.
My son/daughter has the following limitations: _____

_____
Parent/Guardian Name (Print)

_____
Signature **Date**