

San Juan del Rio

YOUTH GROUP FIELD TRIP PERMISSION SLIP

Parent/Guardian Medical Release

1718 State Road 13 North, St. Johns, FL 32259

Sheliah's cell # 728-8251/728-8252 --- Email: Sheliah@sjdrparish.org

NAME OF TEEN: _____ EMAIL OF TEEN: _____
DATE OF BIRTH: _____ SCHOOL: _____ GRADE: _____

NAME OF PARENT/GUARDIAN: _____
HOME ADDRESS: _____ HOME PHONE: _____

EMAIL: _____ CELL PHONE: _____ **Tee—Shirt size:** _____

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 San Juan del Rio Catholic Church 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 San Juan del Rio Catholic Church'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 & RELATIONSHIP: _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

FAMILY HEALTH PLAN CARRIER: _____ POLICY NUMBER: _____

I make the following exception: _____

MY CHILD'S MEDICATIONS/DOSAGES and/or PHYSICAL DISABILITIES:

MEDICATION: _____ DOSAGE: _____ DOCTOR: _____

MEDICAL PROBLEM/CONDITION: _____

SYMPTOMS: _____

MEDICATION: _____ DOSAGE: _____ DOCTOR: _____

MEDICAL PROBLEM/CONDITION: _____

SYMPTOMS: _____

(Parent / Guardian / Representative **Signature**)

(Date)

OTHER MEDICAL TREATMENT: In the event it comes to the attention of San Juan del Rio Catholic Church representatives or volunteers 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.

(Parent / Guardian / Representative **Signature**)

(Date)