

**ST. MATTHEW RELIGIOUS EDUCATION
MEDICAL CONSENT AND PERMISSION TO TREAT**

SCHOOL YEAR 2007 – 2008

My child is in the care of St. Matthew's Religious Education Program for the purpose of this Religious Education activity: **CCD**.

I am giving medical permission and consent to treat.

To the best of my knowledge, my daughter/son, _____, 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 _____ Work Phone _____ Cell Phone _____

If you are unable to reach me, please contact:

Name _____

Relationship to me or my child _____

Home Phone _____ Work Phone _____ Cell Phone _____

Please include a photocopy of your insurance card, front and back.

Insurance Carrier _____ Policy Number _____

My child is taking the following medication(s):

I hereby grant permission for non-prescription medication (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 child without my express permission. I grant such permission ____yes ____no.

My child is allergic to the following: _____.

My child's immunizations are current and up-to-date ____yes ____no.

My child has the following limitations: _____.

My child experiences homesickness, emotional reactions to new situations, sleepwalking, fainting, bedwetting, etc. ____yes ____no.

Please explain: _____

Signature of Parent/Guardian _____

Date _____