

**ANNUAL MEDICAL INFORMATION FORM**  
**(one per youth)**

**Child's Name** \_\_\_\_\_  
Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_  
School \_\_\_\_\_  
Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Father/Guardian's full name: \_\_\_\_\_  
Home Phone : \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Home address: \_\_\_\_\_  
Place of business/address: \_\_\_\_\_ Phone : \_\_\_\_\_

Mother/Guardian's full name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Home address: \_\_\_\_\_  
Place of business/address: \_\_\_\_\_ Phone : \_\_\_\_\_

Relative or friend to contact if unable to reach parent/guardian in the event of emergency:  
Name & Relationship: \_\_\_\_\_  
Phone \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_  
Insurance Policy Number: \_\_\_\_\_  
Insurance is provided by which parent and/or place of employment? \_\_\_\_\_  
Address and Phone Number of Company: \_\_\_\_\_

**MEDICATIONS:** (EITHER A PHYSICIAN'S PRESCRIPTION OR A PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRESCRIPTION / NOTE SHOULD BE ATTACHED TO THIS FORM.) My child is taking the following medication(s):

Description \_\_\_\_\_ Dosage \_\_\_\_\_

Description \_\_\_\_\_ Dosage \_\_\_\_\_

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

Drug Allergies: \_\_\_\_\_

Other Allergies (food, plants, insects, etc.): \_\_\_\_\_

Other known diseases, disorders, or disabilities: \_\_\_\_\_

If you would like your youth to participate in parish activities, please sign and return the following statement of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by your youth.

In consideration for the opportunity for my child to participate in parish activities, and fully recognizing that such an undertaking involves an element of risk, we assume all risks and hazards incidental to such participation and do hereby release, absolve, indemnify and agree to hold harmless the Diocese of Pensacola-Tallahassee and \_\_\_\_\_ Parish, and their employees, agents, volunteers, and other persons acting on their behalf. Neither the Diocese of Pensacola-Tallahassee, \_\_\_\_\_ Parish, nor said agents, employees, or volunteers, shall be held financially responsible for any injury, illness or death incurred as a direct or indirect result of this activity. We the undersigned have read this release and understand all its terms and execute it voluntarily and with full knowledge of its significance.

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I/we hereby authorize the Diocese of Pensacola-Tallahassee, and \_\_\_\_\_ Parish, through its authorized representatives, to transport my child to a hospital or other doctor's office or medical facility for emergency medical attention. I/We additionally authorize such representatives of the Diocese and/or School to obtain and give consent to whatever medical treatment the representative deems necessary, including the administering of anesthetic and surgery, and do hereby release the Diocese and \_\_\_\_\_ Parish, and their authorized representatives from any and all claims which may arise from the above-referenced obtaining and consenting to medical treatment. I/We wish to be advised, if possible, prior to the providing of any non-emergency medical treatment by any physician or hospital.

**Media Release**

Finally, I/we hereby give permission for the Diocese of Pensacola-Tallahassee and any of its affiliated organizations, including, but not limited to The Catholic Compass, to use the name of my child and/or his/her photograph for promotional, news, or public relations purposes in print and/or electronic media.

\_\_\_\_\_  
**Print Parent/Guardian Name**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

**This form is to be kept at the parish and renewed annually**