MEDICAL PERMISSION FORM

Diocese **Dodge City Kansas** Parish _____ School _____

Participants Name _____

Destination _____

TO WHOM IT MAY CONCERN:

I/We understand that first aid will be available on the above trip. I/We further understand that should an accident, injury, or illness occur, medical and/or hospital care will be obtained.

I/We realize that the sponsors will make a reasonable effort to notify me/us in case of accident, injury, or illness: however, should they be unable to contact me/us, they have my permission to pursue a course of medical action which is in the best interest of the child.

I/We grant permission to the administration of first aid care to_____by the people in charge and those transporting my child to and from as their judgment deems advisable and to make the necessary referrals to qualified physicians or health care providers for treatment of illness or accidents. I/We understand that a reasonable effort will be made to promptly notify me in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, in the event I/we cannot be reached, I/we hereby give permission to the physician or health care provider selected by the adult staff to hospitalize, secure proper treatment for, and order whatever injection, anesthesia, or surgery said physician or health care provider deems necessary for the child.

A doctor, clinic, hospital, or health care provider may proceed with a medical or surgical treatment that such sponsor may authorize.

I further understand that I will be responsible for all medical, surgical, and transportation costs which may be incurred.

INSURANCE INFORMATION:

Insurance Company Policy No. _____

_____ _____

(Father) (Home & Work Telephone #)

_____ _____

(Mother) (Home & Work Telephone #)

If unable to contact either parent above, I/we grant permission to contact:

_____ _____

(Friend or Relative) (Home & Work Telephone #)

_____ _____

(Family Physician) (Physician's Telephone #)

_____ _____ _____ _____

Parent/Legal Guardian Signature Date Parent/Legal Guardian Signature Date

If there are any medical restrictions/problems – please note them on the back of this sheet.