ACKNOWLEDGEMENT AND MEDICAL AUTHORIZATION
EPISCOPAL DIOCESE OF SOUTHEAST FLORIDA
525 NE 15th Street, Miami, FL 33132, 305-373-0881

I/we, the undersigned parent(s) or guardian(s) of _____, do hereby grant permission for my child to travel to and participate in the various functions of The Episcopal Diocese of Southeast Florida (DIOSEF) occurring throughout the United States and abroad from _____. Included in this authorization is the understanding that my child may travel in a vehicle provided by the DIOSEF for the specific function, provided that a responsible adult will drive this vehicle. Additionally, my child may participate in any media-related photographs or taping for airing or print of this program/event.

During the effective dates of this document, authority is granted to the DIOSEF or its designee, to seek and authorize appropriate medical treatment, procedures and medication on behalf of the child as may be required by the circumstances, including, but not limited to medical doctors, medication and/or hospital visits. Prior to authorizing any medical treatment, procedures or medication, _____ (adult in charge), or their designee, must make reasonable efforts to contact me at the phone numbers listed below.

By our signature(s) below, I/We hereby release and hold harmless The Diocese of Southeast Florida, and the youth event leader(s) from all liability to my child while attending church-sponsored activities. I/we acknowledge the fact that the Church and the Diocese of Southeast Florida do not carry a student accident policy on my child. Therefore I/we the parent(s) or guardian(s) must provide my/our own medical insurance and provide the necessary information on this form.

MEDICAL INFORMATION

To be completed by parent(s) or guardian(s). Please type or print clearly all information (both parents or guardian must sign).

Physician's Name _____ Phone _____

Insurance Co. _____ Policy/Membership # _____

My child has had a tetanus immunization in the last 10 years: YES NO

My child is allergic to the following medications:

_____

My child is presently on the following medications:

_____

My child has the following special medical problems, which might require the following treatments:

_____

The adult in charge has permission to administer the following medications: *(Check all that apply)*

___Ibuprofen ___Tylenol ___Benadryl ___Claritin ___Neosporin ___Bactine ___Pepto Bismol ___Zantac

___Sting Relief ___Hydrocortizone Cream ___Opcon A (eye drops) ___Natural Tears (eye drops) ___Immodium

Signature(s) of Parent(s) or guardian(s):_____

_____Date signed: _____

Please print your name(s): _____

Address _____ City _____ State/Zip _____

Attempt to contact me at these phone numbers: Home: _____

Cell: _____ Other: _____