District Council of Madison, Inc., Society of St. Vincent de Paul
Madison SVdP Youth Service Council

Medical Consent Form

I hereby attest that to the best of my knowledge my son/daughter is in good health and that I assume responsibility for the health of my son/daughter.

(Please check one.)

☐ Yes ☐ No

In the event of an emergency, I give permission for my son/daughter to be transported to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

☐ Yes ☐ No

I grant permission for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my son/daughter, if deemed advisable. I understand that Aspirin will not be given to my son/daughter.

☐ Yes ☐ No

I understand that my son/daughter, and not District Council of Madison, Inc. – Madison SVdP Youth Service Council staff members or volunteers, is responsible for administering/taking any prescribed medications necessary unless specific and mutually-agreed upon arrangements have been made with the aforementioned staff members or volunteers.

☐ Yes ☐ No

My son/daughter is taking the following medication(s) at the present time:
_____

My son/daughter has the following allergies (food or otherwise):
_____

Please list any other medical conditions of which we should be aware: _____
_____

Name of Insurance Carrier: _____

I hereby agree that my answers to the above questions are complete and true.

_____ _____
(signature of parent/guardian) *(date)*
(*parent/guardian signature*) (*date*)

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