Official legal form for the Diocese of Salina

FORM B - MEDICAL INFORMATION

This form should be completed for any person (under 19 years of age) in parish religious education, Catholic schools, and youth ministry programs and should be completed on an annual basis at the beginning of the program.

Diocese: Salina Parish St. Joseph School Faith Formation

Participant's Name _____

Date of Birth_____ Place of Birth_____

Participants Regular Physician:
Name (first, middle, last): _____ Phone (including area code): _____

Medical Conditions:
Please list any medical conditions of the participant (asthma, diabetes, epilepsy, etc…): _____

_____

List below any physical condition the sponsors, doctors, nurses, or other medical personnel should be aware of:
Insect stings:_____ Fainting Spells:_____
Allergies:_____ Ear Infections:_____
Seizures:_____ Heart Condition:_____
Headaches:_____ Other:_____

List any allergies or allergic reactions to medications of the participant: _____

Other pertinent medical information: _____

Dates of Participant's last immunizations: MMR_____TB _____ TETANUS _____

Special dietary needs/restrictions: _____

Medications:
Prescribed medication now being taken:
Type: _____ Dosage: _____ How often: _____
Activities individual should not participate in: _____

Medical Insurance Information:
Company: _____
Plan Number: _____ Employee Identification #: _____

Emergency Contacts:

Parent or Guardian Name (first, middle, last): _____
Daytime Phone (including area code): _____ Evening Phone (including area code): _____

Other Contact:

Name (first, middle, last): _____ Phone (including area code): _____
Relationship (friend, neighbor, coworker, etc): _____

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FORM C - PARENTAL or GUARDIAN MEDICAL CONSENT FORM AND LIABILITY WAIVER

This form is to be used for any parish, Catholic school, youth ministry and diocesan field trips.

Date:_____

Diocese: Salina Parish St. Joseph School Faith Formation
Destination _____
Name of Participant (minor): _____
Home address:_____
Cell Number _____ Home Phone Number _____ Business Number _____

MEDICAL MATTERS:

The Parish/School/Organization will take all reasonable and prudent care to see that confidentiality regarding the following information is maintained.

I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. I/We understand and acknowledge that any medical expenses related to illness or injury to my/our child are not covered by an insurance program maintained by the Parish/School/Organization or the Diocese of Salina, and that I/we am/are responsible for such expenses.
I/We understand that first aid will be available on the above-mentioned trip. I/We further understand that should an accident, injury, or illness occur, medical and/or hospital care will be obtained. I/We realize 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/our permission to pursue a course of medical action which is in the best interest of the child.
I/We understand that a reasonable effort will be made to promptly notify me/us 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 any 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.

_____

Signature: _____ Date _____
Parent Or Guardian

Signature: _____ Date _____
Parent or Guardian

INSURANCE INFORMATION:

Insurance Company _____ Policy No. _____

Policy Holder _____ Date of Birth _____ Occupation _____

Employer _____ Address _____

Employer's phone # _____

** If Blue Cross/Blue Shield Insurance please state if it is Blue Choice, Blue Select, etc.

HIPAA FORM - ROMAN CATHOLIC DIOCESE OF SALINA AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME	BIRTH DATE

CHECK ONE:

BY SIGNING BELOW, I HEREBY AUTHORIZE ANY HEALTH CARE PROVIDER THAT HAS PROVIDED TREATMENT TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO:

Catholic Chancery Office
103 N. 9th Street, P.O. Box 980
Salina, Kansas 67402-0980

For Treatment date(s):_____September 6, 2023 - May 1, 2024_____
Specify date(s) - this line MUST BE completed

For the following purpose(s): EmergencyAt the request of the patient_____

If the request is initiated by the patient (Or patient representative), insert "at the request of patient;" otherwise, describe purpose of use or disclosure.

If the purpose relates to marketing, indicate whether Provider will receive remuneration.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED
(Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provides unless records were prepared on behalf of Provider

- ☐ Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected)
- ☐ Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.
- ☐ Other _____

_____ *Date*

_____ *Signature of Authorized Agent/Representative (Parent)*

_____ *Printed Name of Authorized Agent/Representative (Parent)*

_____ *Relationship of Authorized Agent/Representative*

_____ *Address of Authorized Agent/Representative*

_____ *Telephone # of Authorized Agent/Representative*

_____ *Date*

_____ *Signature of Witness*

ORIGINAL - Privacy Officer COPY - Patient Medical Record

For Office Use Only: For each disclosure made pursuant to this authorization, list the name of the person/entity to whom the disclosure was made; a description of the disclosed; the date on which the disclosure was made; any fees charged in connection with the disclosure; and the name of the person making the disclosure.