

## HOLY FAMILY CHURCH CONFIRMATION

1527 Fremont Avenue | South Pasadena, CA 91030

Part A to be completed by a licensed physician unless copy of prescription and original prescription bottle is provided containing the information requested in Part A.

I hereby request that my son/daughter be allowed to take the following medication(s) at Holy Family Church and/or at a Holy Family Church's sponsored field trip, event or activity.

\_\_\_\_\_  
Teen's Last Name                                      First Name                                      Sex                                      Birth Date

\_\_\_\_\_  
Name, Address and Phone Number of Physician

Name of Medication(s): \_\_\_\_\_

**A. PHYSICIAN'S INSTRUCTIONS** (Complete where applicable)

\_\_\_\_\_  
Purpose of Medication or Diagnosis

\_\_\_\_\_  
Dosage Prescribed                                      Date/Time Schedule                                      Dose Form (tablet, liquid, etc.)

Please notify this office if patient misses medication: Yes \_\_\_\_ No \_\_\_\_

Medication may have adverse effects (explain) \_\_\_\_\_  
\_\_\_\_\_

Special instructions and/or comments: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print Name of Licensed Physician                                      Signature of Licensed Physician

\_\_\_\_\_  
Address                                      Telephone                                      Date

**B. PERMISSION FOR ADMINISTRATION OF MEDICATION AND/OR TESTING AT HOLY FAMILY CHURCH AND/OR AT HOLY FAMILY CHURCH'S FIELD TRIP/EVENT/ACTIVITY:**

I request that my son/daughter identified above, be permitted to carry and use emergency medication (inhaler, epi-pen, insulin, etc.) and/or test for levels of blood sugar at Holy Family Church identified above and/or at a Holy Family Church sponsored field trip/event/activity as prescribed by the physician above. I acknowledge and understand that no health care professional or other trained adult may be available at Holy Family Church or at the field trip/event/activity to assist, monitor or supervise my son/daughter's self-administration of medication or testing unless arrangements have been made in advance. In the event that my son/daughter is unable to self-administer or self-test, I agree that Holy Family Church staff/chaperones may assist my son/daughter to the extent possible under the circumstances, but neither they nor Holy Family Church shall be liable for any adverse consequences or injury. I hereby give Holy Family Church staff/chaperones permission to call paramedics to render treatment to my son/daughter should that be necessary and to release medical information to first responders for that purpose.

For all other medications, my son/daughter and I will comply with Holy Family Church's policies and procedures and will provide Holy Family Church with any medication my son/daughter requires in its original prescription bottle.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_