Health History and Medical Release Form for Parish Programs and Activities

Participant's Name_____ Sex_____ Birthdate_____-_____-_____ Age_____

Parent/Guardian_____ Relation to participant_____

Street Address_____ City_____ State_____ Zip_____

Home Telephone (_____)_____Work Telephone (_____)_____

HEALTH HISTORY

Family Doctor_____ Telephone Number (_____)_____

IMMUNIZATIONS (Record YEAR of last immunization or last time person had disease):

Tetanus/Diptheria_____	Chicken Pox_____	TB (results_____
Measles_____	Rubella_____	Hepatitis B_____
Mumps_____	Polio_____	Other_____

SEPCIAL INFORMATION (Please check all that apply—information will be held in strict confidence):

Sleep walking_____	Kidney Problems_____	Severe Headaches_____
Fainting_____	Frequent Nosebleeds_____	Diabetes_____
Dizziness_____	Frequent Colds_____	Severe Homesickness_____
Blackouts_____	Seizures_____	Frequent Earaches_____
Asthma_____		

ALLERGIC REACTIONS (Please list all known allergies—plant, insect, food, medicine, AND TYPE OF REACTION):

_____

Please indicate any other medical problems/situations pertinent to your child:

_____

Any physical limitations?_____ If yes, explain_____
Any emotional/psychological limitations or reactions to be aware of?_____ If yes, explain:

_____

Is the student taking any medication?_____ All medication is to be well labeled with clear, concise directions indicated here (frequency, dosage, etc.):

_____

In an **EMERGENCY**, and unable to reach parent/guardian, contact:

1. Name_____ Telephone (___)_____
2. Name_____ Telephone (___)_____

****** PLEASE FILL OUT BOTH SIDES ******

Note to parent/guardian: Please read the following sections over carefully. We apologize for the complexity but we must be sure we have your full consent in these areas.

PERMISSION FOR ROUTINE MEDICAL TREATMENT:

All attempts **will** be made to notify you if your child requires medical treatment (i.e., cases of high, persistent fever; severe vomiting, etc.). Please indicate whether or not you wish attempts to be made to contact you if your child becomes ill with minor symptoms (I.e., headache, sore throat, low-grade fever, etc.). **YES_____NO_____**

We do not wish to give any medical treatment to your son/daughter against your wishes or family practice. Please read each of the following statements carefully and **sign either A or B** which is in accord with your wishes:

A) I grant permission for non-prescription medication (I.e., Tylenol, cough syrup, etc.) except for the following_____ to my student if deemed advisable by the designated supervisor, and I grant permission for routine non-surgical medical care to be given to my student, if deemed advisable by the designated supervisor(s).

*SIGNATURE_____ DATE_____

OR

B) I do not want ANY type of medication administered to my child unless the situation is life-threatening and emergency treatment is required.

*SIGNATURE_____ DATE_____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, I hereby give permission to Old St. Patrick Catholic Church to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor and I recognize that I am financially responsible.

*SIGNATURE_____ DATE_____

FAMILY INSURANCE PROVIDER/HEALTH PLAN_____

HEALTH PLAN NUMBER (Include expiration date):_____