

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/Diphtheria _____ Chicken Pox _____ TB (results) _____
Measles _____ Rubella _____ Hepatitis B _____
Mumps _____ Polio _____ Other _____

SPECIAL 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): _____