



To Be Filled Out By OBOC Nursing Staff Only:

Medical Alert:  No  Yes \_\_\_\_\_  
Drug Allergies: \_\_\_\_\_  
Notes: \_\_\_\_\_  
\_\_\_\_\_

**M E D I C A L H I S T O R Y - Y O U T H P A R T I C I P A N T**

**IMPORTANT: ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD**

*I do not have health/medical insurance at this time*

Saint Meinrad Seminary and School of Theology desires that the *One Bread, One Cup* Summer Liturgical Leadership Conference be safe and healthy for all participants. In case of illnesses or accidents, we must have the following information. *Please be thorough in completing this form and do not leave any blanks in order to prevent delays at registration.*

**YOUTH PARTICIPANT:** First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Attending Conference # \_\_\_\_\_ With \_\_\_\_\_ (Name of Parish or HS Group)

**PRIMARY EMERGENCY CONTACT:** \_\_\_\_\_ Relationship \_\_\_\_\_

(parent/legal guardian)

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**HEALTH HISTORY:** *Indicate if you currently experience and/or are being treated for any of the following conditions.*

- No  Yes - Contact Lenses
- No  Yes - Infection (Ear, Throat, Skin, etc.)
- No  Yes - Diabetes
- No  Yes - Leukemia/Cancer
- No  Yes - Other \_\_\_\_\_
- No  Yes - Other \_\_\_\_\_
- No  Yes - Asthma, *controlled by:*
  - Oral medication: \_\_\_\_\_
  - I carry an INHALER to control my asthmatic attacks

- No  Yes - Bleeding or Clotting
- No  Yes - Convulsions
- No  Yes - Heart Disease
- No  Yes - Hypertension

- Allergies:
- I carry an EPIPEN because of a severe allergy to \_\_\_\_\_
  - No  Yes - Food Allergies: \_\_\_\_\_
  - No  Yes - Seasonal Allergies: \_\_\_\_\_
  - No  Yes - Drug Allergies: \_\_\_\_\_
  - No  Yes - Other Allergies: (ex: bee stings): \_\_\_\_\_

Date of last Tetanus Booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Are you a vegetarian*  No  Yes - *specifics of my diet:* \_\_\_\_\_

Do you have special needs you would like us to be aware of (e.g., dietary restrictions, physical or mental impairment)?

No  Yes - *please explain:* \_\_\_\_\_

Recent Operations or serious injuries or trauma (include dates)  No  Yes - *please explain:* \_\_\_\_\_

Current medications (*please list*): \_\_\_\_\_

**REQUIRED** Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## PARENTAL CONSENT FOR MEDICAL TREATMENT FOR YOUTH PARTICIPANT

In case of any onset of sudden illness or accidents, Saint Meinrad School of Theology (Saint Meinrad) requires each participant to have a Medical History and each high school youth participant a Parental Consent for Medical Treatment on file while at Saint Meinrad. Medical records will be retained for 60 days. Saint Meinrad will retain, for a period of no less than seven years, a copy of the medical history, parental consent and any other relevant documentation for anyone who receives medical assistance while at Saint Meinrad.

Saint Meinrad recognizes its responsibility to provide the needed supervision and safety as required by the United States Conference of Catholic Bishops *Charter for the Protection of Children and Young People* established in June 2002. Two members of the Saint Meinrad staff, one of the opposite sex, will accompany and remain appropriately present while seeking emergency treatment.

HIPPA compliance requires Saint Meinrad to communicate directly with parents and guardians, not diocesan directors, campus or youth ministers, or adult chaperones unless a corresponding release is on file with Saint Meinrad.

*Please read the statement in bold letters below and complete all of the requested information.*

**In case of medical emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give Saint Meinrad School of Theology the permission to act in my behalf in seeking emergency treatment for my child in the event that such treatment is deemed necessary by Saint Meinrad School of Theology. I give permission to those administering emergency treatment to do so, using those measures deemed necessary. I absolve Saint Meinrad Archabbey and School of Theology from liability in acting on my behalf in this regard.**

Youth Participant's Name \_\_\_\_\_  
(please print)

Youth Participant's Social Security # \_\_\_\_\_

If Parent/Legal Guardian is not available, please contact the  
Following person as a Secondary Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Legal Guardian Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

**\*\*REQUIRED\*\***

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD NOW**