

**HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR PARISH PROGRAMS AND ACTIVITIES**

Participant's Name _____ Sex _____ Birth Date _____ Age _____
Parent/Guardian _____ Relationship to participant _____
Street Address _____ City _____ State _____ Zip Code _____
Home Telephone () _____ Work Telephone () _____

HEALTH HISTORY

Family Doctor _____ Telephone Number () _____

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

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

SPECIAL INFORMATION: (Please check all that apply. Information will be held in strict confidence.)

Sleep Walking _____	Fainting _____	Dizziness _____
Blackouts _____	Asthma _____	Kidney Problems _____
Frequent Nosebleeds _____	Frequent Colds _____	Seizures _____
Severe Headaches _____	Diabetes _____	
Severe Homesickness _____	Frequent Earaches _____	

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

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

1. Name _____ Telephone Number () _____
2. Name _____ Telephone Number () _____

PLEASE FILL OUT BOTH SIDES

Note to parent/guardian: Please read the following sections carefully. We apologize for the complexity but we must be sure we have your full consent in these areas as well as, having this document notarized.

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** _____

NOTE: If you do wish to be contacted and it is not a local call, the charges shall be reversed to you.

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 only 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 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.

*SIGNATURE _____ DATE _____

FAMILY INSURANCE PROVIDER/HEALTH PLAN _____

HEALTH PLAN NUMBER (Include expiration date): _____