

Health History and Medical Release Form for Parish Programs/Activities 2017-18

Participant Information

Participant's Name _____	Sex _____	Birthdate _____	Age _____
Parent/Guardian _____	Relationship to Participant _____		
Street Address _____	City _____	State _____	Zip _____
Home Phone # _____	Work Phone # _____		

If the information regarding shots has not changed since last year, please write same and initial the area. Complete the rest of the form.

Health History

Family Doctor _____ Telephone Number _____

Immunizations

Tetanus	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Rubella	<input type="checkbox"/>		
TB	<input type="checkbox"/>	Mumps	<input type="checkbox"/>		
Results _____					

Special Information: Please check all that apply – information will be held in strict confidence.

Sleepwalking	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Severe Headaches	<input type="checkbox"/>	Severe Homesickness	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Frequent Earaches	<input type="checkbox"/>				

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? yes no

If yes, please explain:

Any emotional/psychological limitations or reactions to be aware of? yes no

If yes, please explain:

Is the student presently taking any medication? yes no

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 _____

Note to parent/guardian: Please read the following sections over carefully. We apologize for the complexity, but we must be sure we have our 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.).

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-prescribed medication (i.e. Tylenol, cough syrup, etc.) except for the following _____ 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) _____

Please fill out both sides