Health History and Medical Release Form for Parish Programs/Activities 2015-2016

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	☐	Measles	☐	Polio	☐
Chicken Pox	☐	Rubella	☐		
TB	☐	Mumps	☐		

Results ___________________

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

Sleepwalking	☐	Fainting	☐	Dizziness	☐
Blackouts	☐	Asthma	☐	Kidney Problems	☐
Nosebleeds	☐	Frequent Colds	☐	Seizures	☐
Severe Headaches	☐	Severe Homesickness	☐	Diabetes	☐
Frequent Earaches	☐				

Allergic Reactions: Please list all known allergies – plant, insect, food, medicine AND TYPE OF REACTION

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

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____

____

____

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.)

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Please fill out both sides

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 sing 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) _____________________________________