HEALTH HISTORY & MEDICAL RELEASE FOR PARISH PROGRAM/ACTIVITIES

Name_____ Sex____ Birth Date_____ Grade____

Parent/Guardian_____ Relation to Participant_____

Street Address_____ City_____ State ____ Zip Code_____

Home Phone (_____)_____ Work Phone (_____)_____

HEALTH HISTORY

Family Doctor_____ Phone Number (_____)_____

Are the following immunizations current for your child?

(Please write "yes" or "no" next to every immunization)

Tetanus/Diphtheria_____ Measles_____ Mumps_____

Chicken Pox_____ Rubella_____ Polio_____

Has the child ever been tested for TB?_____ Were the results of the test ever positive?_____

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_____ Severe Homesickness_____ Diabetes_____

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 medications? _____ 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_____ Phone (_____)_____
2. Name_____ Phone (_____)_____

*** PLEASE FILL OUT BOTH SIDES! ***

Note to parent/guardian: Please read BOTH of the following sections over carefully and **fill out completely**. We apologize for the complexity, but we must be sure we have your full consent in these areas.

PERMISSION FOR ROUTINE MEDICAL TREATMENTS

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 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 _____

EXPIRATION DATE _____