

# HEALTH HISTORY & MEDICAL RELEASE FOR PARISH PROGRAM/ACTIVITIES

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Relation to Participant \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Other 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 \_\_\_\_\_