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 ( ) _____

H E A L T H H I S T O R Y

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

PERMISSION FOR ROUTINE MEDICAL TREATMENT

All attempts **<u>will</u>** 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): _____