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_____

Phone Number _____

Allergic Reactions (Please list all know 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 (frequency, dosage, etc _____

In an EMERGENCY, and if unable to reach parent/guardian we should contact:

1. Name_____ Phone Number_____
2. Name_____ Phone Number_____

Note parent/guardian: Please read the following sections carefully. We apologize for the complexity but we must be sure we have your full consent in these areas as well as having this document notarized.

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 (ie: 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 (ie 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_____