(Please fill out a medical form for each child you are registering)

HEALTH HISTORY AND MEDICAL RELEASE FORM FOR PARISH PROGRAMS AND ACTIVITIES

Participant's Name _____Sex ___ Birth date _____ Grade ____
Parent/Guardian _____ Relationship to participant _____
Street Address _____City _____ State _____ Zip Code _____
Home phone ( ) _____ Work phone ( ) _____ Cell ( ) _____

HEALTH HISTORY

Family Doctor _____ Telephone Number ( ) _____

IMMUNIZATIONS (Record YEAR of last immunization, or last time person had disease**. If unsure of dates may also mark with a "UTD" for "Up To Date").**

Tetanus/Diphtheria _____ Measles _____ Mumps _____ Chicken Pox _____ Rubella_____
Polio _____ TB _____(results) _____ Other _____ Hepatitis B _____

SPECIAL INFORMATION: (Please check all that apply. Information will be shared on a "need to know" basis or shared with appropriate staff.)

Fainting _____ Dizziness _____Blackouts _____ Asthma _____Kidney Problems ____ Frequent Nosebleeds_____
Seizures _____ Severe Headaches _____Diabetes _____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? _____ If so please indicate which medication below.

_____

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

1. Name _____ Telephone Number _____
2. Name _____ Telephone Number _____

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): _____