Saint John *the* Evangelist
CATHOLIC CHURCH OF ENCINITAS

# 2026-2027
# Medical Information Form

*One form must be completed per child and is valid for one year or until any medical, insurance, or contact information changes — it is the responsibility of the parent/guardian to notify St. John Youth Ministry Office of any updates promptly*

**Child's Name:** _____

**Date of Birth:** _____ ☐ Male ☐ Female

**Parent/Guardian Name(s):** _____

**Home Address:** _____

**Contact Phone(s):** _____

**Basic Medical Information**

Does your child have health insurance? ☐ Yes ☐ No

Does your child have Chronic Medical Problems or Physical Restrictions
(e.g. asthma, diabetes, depression, ADHD)? ☐ Yes ☐ No

**Current Medications and Dosages** (include both prescription and over-the-counter; write "N/A" if none):

| |
|---|
| |

**Does your child carry any of the following?**

☐ EpiPen ☐ Inhaler ☐ None ☐ Other (please explain): _____

**Medical Matters**

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Signature: _____ Date: _____

**In the event of an emergency, if you are unable to reach me at the above numbers, contact:**

Emergency Contact
Name & Relationship: _____ Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____

Policy Number: _____

*Continues on next page*

**Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

**Signature: _____ Date: _____**

In the event it comes to the attention of the parish, the Diocese of San Diego, its officers, directors, agents, volunteers, chaperones, and representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever or diarrhea, I want to be contacted.

**Signature: _____ Date: _____**

## MEDICATIONS:

My child is taking medication at present. My child will bring all medications necessary, and such medications will be well labeled. Names of medications and concise instructions for seeing that child takes such medications, including dosage and frequency of dosage is as follows:

| |
|---|
| |

**Signature: _____ Date: _____**

## MEDICATIONS: CHOOSE ONE OF THE BELOW LISTINGS: (A OR B)

**A)** No medication of any type whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

**A) Signature: _____ Date: _____**

**B)** I hereby grant permission for nonprescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed available.

**B) Signature: _____ Date: _____**

## SPECIFIC MEDICAL INFORMATION

The parish will take reasonable care to see that the following information will be held in confidence.

- Allergic reactions (medications, foods, plants, insects, etc.): _____
- Immunizations: Date of last tetanus/diphtheria immunization: _____
- Does child have a medically prescribed diet? _____
- Any physical limitations? _____
- Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____
- Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, H1N1, etc.? If so, date and disease or condition: _____
- You should be aware of these special medical conditions of my child:_____
  _____