

THE CHURCH OF THE HOLY SPIRIT
OFFICE OF YOUTH MINISTRY
PENSACOLA, FLORIDA
DIOCESE OF PENSACOLA-TALLAHASSEE



-2009-

YOUTH MEDICAL INFORMATION FORM

-2009-

CONTACT INFORMATION: *(Please Print)*

Youth's name: _____

Date of Birth: _____ Gender: Female Male Grade: _____

Home address: _____

▪ Mother's name: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

Preferred Email Address: _____

▪ Father's name: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

Preferred Email Address: _____

▪ Emergency Contact: _____ Relationship to youth: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

MEDICAL INFORMATION: *(Please answer all of the following questions)*

The Church of the Holy Spirit and its authorized representatives will take reasonable care to see that the following information will be held in confidence.

- **Is youth taking prescription medication?** Yes No **If yes, please explain if necessary** (attach additional sheets as needed): _____

- **Does youth have any allergies? (adverse reactions to medications, foods, plants, insects, etc.)**
 Yes No **If yes, please explain** (attach additional sheets as needed): _____

- **Does youth have a medically prescribed diet?** Yes No **If yes, please explain** (attach additional sheets as needed): _____

- **Does youth have any physical limitations?** Yes No **If yes, please explain** (attach additional sheets as needed): _____

-Both sides of this form must be completed-

- **Has youth recently been exposed to contagious disease or condition (mumps, measles, chicken pox, etc.)?** Yes No **If yes, please explain listing date and disease or condition (attach additional sheets as needed):** _____

- **Does youth have any other medical/behavioral conditions that should be noted?** Yes No **If yes, please explain please list date and disease or condition (attach additional sheets as needed):**

- **List the date of youth’s last tetanus/diphtheria immunization. Month:** _____ **Year:** _____

Health Plan Carrier: _____

Group #: _____ **Policy #:** _____

Family doctor: _____ **Phone:** _____

CONSENT TO EMERGENCY MEDICAL TREATMENT:

In the event of an emergency, I/we hereby authorize the Diocese of Pensacola-Tallahassee, and **Holy Spirit** Parish, through its authorized representatives, to transport my child to a hospital or other doctor’s office or medical facility for emergency medical attention. I/We additionally authorize such representatives of the Diocese and/or School to obtain and give consent to whatever medical treatment the representative deems necessary, including the administering of anesthetic and surgery, and do hereby release the Diocese and **Holy Spirit** Parish, and their authorized representatives from any and all claims which may arise from the above-referenced obtaining and consenting to medical treatment.

I/We wish to be advised, if possible, prior to the providing of any non-emergency medical treatment by any physician or hospital. In the event of an emergency, if you are unable to reach me please contact the person I designated as “emergency contact”. **I accept full responsibility for any medical or hospital bills associated with the care of my youth.**

I certify that the information contained herein is true and correct to the best of my knowledge and that my youth is in good health, and I assume all responsibility for the health of my youth.

Print Parent/Guardian Name

Parent/Guardian Signature

Date

*This form must be completed once per youth, per year. Youth participating in ANY activity sponsored by Holy Spirit Church **MUST** have a current, up-to-date form on file with the office of the Parish Coordinator of Youth Ministry.*