

**DIocese of Lansing and St. Andrew Catholic Religious Education**  
**HEALTH HISTORY AND MEDICAL RELEASE FORM**  
**FOR PARISH PROGRAM AND ACTIVITIES**

Participants Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Cell/Work Telephone (\_\_\_\_) \_\_\_\_\_

Student's Grade: \_\_\_\_\_ Grad. Yr. 20 Day Attending: \_\_\_\_\_ Time Attending: \_\_\_\_\_

**HEALTH HISTORY**

Family Doctor \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**IMMUNIZATIONS** up to date? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ (if **NO**, record **YEAR** of last immunization or last time person had disease)

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

**SPECIAL INFORMATION**

Information will be shared on a "need to know" basis with appropriate staff/volunteers only

**CONDITION(S)** (please check all that apply and describe them below)

Allergies _____	Fainting Spells _____	Seizures _____
Asthma _____	Frequent Colds _____	Severe Headaches _____
Blackouts _____	Frequent Earaches _____	Severe Homesickness _____
Diabetes _____	Frequent Nosebleeds _____	Other _____
Dizziness _____	Kidney Problems _____	Other _____

**DESCRIPTION:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS:** Is your child taking any medication? \_\_\_\_\_ If yes, list name of medication(s), frequency and dosage: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AIDE:** Does your child require an aide? \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is the aide needed full time? \_\_\_\_\_ or part-time? \_\_\_\_\_ other? \_\_\_\_\_

**HEALTH HISTORY AND MEDICAL RELEASE FORM (CONTINUED)**

**LIMITATIONS:** Does your child have any **PHYSICAL LIMITATIONS**? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

---

---

---

Does your child have any **EMOTIONAL/PSYCHOLOGICAL LIMITATIONS**? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

---

---

---

Does your child have a **LEARNING DISABILITY**? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

---

---

---

**EMERGENCY INFORMATION**

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

- 1) Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_
- 2) Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**PERMISSION FOR MEDICAL TREATMENT**

In case of **EMERGENCY**, I hereby give permission to transport my child to the nearest hospital/emergency center for 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 Number \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**\*\* IMPORTANT \*\***

**If your child's medical condition changes,  
it is your responsibility to contact the parish office  
so that we can update medical information.**

*This form is effective June 1, 2009 – October 1, 2010*

(over)