

**HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR PARISH PROGRAM/ACTIVITIES**

FAMILY INFORMATION:

Parent/Guardian _____ Relation to Child _____
(First and Last Name)

Street Address _____ City _____ State _____ Zip _____

Home Telephone Number () _____ Work Telephone Number () _____

Family Doctor _____ Telephone Number () _____

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

1. Name _____ Telephone () _____

2. Name _____ Telephone () _____

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): _____

*****PLEASE COMPLETE THE FOLLOWING CHILD'S HEALTH HISTORY FOR
EACH CHILD REGISTERED IN ST. JOSEPH RELIGIOUS EDUCATION PROGRAM
(USE BACK OF THIS FORM FOR ADDITIONAL CHILDREN)*****

CHILD'S HEALTH HISTORY

Child's Name _____ Sex _____ Birthdate ____ - ____ - ____ Age _____
(First and Last Name)

IMMUNIZATIONS.....All up to Date? _____

OR Record YEAR of last immunization or last time person had disease):

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

SPECIAL INFORMATION (Please check all that apply—information will be held in strict confidence):

Sleep Walking _____	Fainting _____	Dizziness _____
Blackouts _____	Asthma _____	Kidney Problems _____
Frequent Nosebleeds _____	Frequent Colds _____	Seizures _____
Severe Headaches _____	Severe Homesickness _____	Diabetes _____

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? _____ All medication is to be well-labeled with clear, concise directions indicated here (frequency, dosage, etc.):

Note to parent/guardian: Please read the following sections over carefully. We apologize for the complexity but we must be sure we have your full consent in these areas.

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 (i.e., 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 (i.e., 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 _____