HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR PARISH PROGRAMS AND ACTIVITIES

Participant's Name _____Sex _____ Birthdate _____ Age ____

Parent/Guardian _____ Relationship to participant _____

Street Address _____City _____ State _____ Zip Code _____

Home Telephone ( ) _____ Work Telephone ( ) _____

H E A L T H H I S T O R Y

Family Doctor _____ Telephone Number ( ) _____

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

Sleep Walking _____	Fainting _____	Dizziness _____
Blackouts _____	Asthma _____	Kidney Problems _____
Frequent Nosebleeds _____	Frequent Colds _____	Seizures _____
Severe Headaches _____	Severe Homesickness _____	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? _____ All medication is to be well labeled with clear, concise directions indicated here (frequently, dosage, etc.):

_____

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

1. Name _____ Telephone Number ( ) _____

2. Name _____ Telephone Number ( ) _____

PLEASE FILL OUT BOTH SIDES *PLEASE COMPLETE 2 COPIES OF THIS FORM*

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): _____

NOTARY INFORMATION BELOW
NOT REQUIRED BY DIOCESE
ONLY USE IF PARISH REQUIRES

Subscribed and sworn to before me on this ____ of _____, 20__.

_____
(Signature)

Notary Public for _____ County,
Michigan.

My commission expires on _____.