

SS CHARLES & HELENA CHURCH
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() _____

HEALTH HISTORY

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() _____ **(fill out back!!!!)**

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): _____