

**HEALTH HISTORY AND MEDICAL RELEASE FORM
ST. MARY PARISH HIGH SCHOOL YOUTH PROGRAM**

(Please fill out one form for each child)

Participant's Name _____ Sex _____ Birth Date _____ Age _____
Parent/Guardian _____ Relationship to participant _____
Street Address _____ C/S/Z _____
Home Phone _____ Work Phone _____

HEALTH HISTORY

Family Doctor _____ Phone Number _____

IMMUNIZATIONS Record the YEAR of last immunization. *(Information requested per Diocesan policy)*

Tetanus/Diphtheria _____	Measles _____	Mumps _____
Chicken Pox _____	Rubella _____	Polio _____
TB _____ (results) _____	Hepatitis B _____	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 _____	Diabetes _____	Severe Homesickness _____
Frequent Ear aches _____		

ALLERGIC REACTIONS (Please list all known allergies – plant, insect, food, medicine
AND the type of reaction we can expect.)

Please describe any medical problems or issues with your child we should know about:

Any physical limitations? _____

Any emotional/psychological limitations or reactions? _____

Presently taking medication? _____

Medications must be well labeled, including clear directions for dose, frequency, etc. (list them on line below)

In an **EMERGENCY**, if we cannot reach the parent/guardian, we should contact:

1. Name _____ Phone Number _____

2. Name _____ Phone Number _____

---- PLEASE FILL OUT THE BACK SIDE OF THIS FORM ----

Note to parent or guardian:

Please read the following sections carefully. We apologize for the paper work, but we must be certain we have your full consent for medical treatment.

PERMISSION FOR ROUTINE MEDICAL TREATMENT

We will persistently try to contact you if your child requires treatment for medical issues such as (high fever, persistent vomiting or other more severe issues). Please indicate whether or not you want us to contact you if your child becomes ill with minor symptoms such as (headache, sore throat, low-grade fever, etc.)

circle yes or no **YES** **NO**

We do not want to give any medical treatment to your son/daughter against your wishes or family practice. Please read each of the following statements carefully and decide whether A or B is in accord with your wishes.

Sign A or B (not both)

A. Except for the following _____ I grant permission for non-prescription medication such as (Tylenol, cough syrup, etc.) and for routine non-surgical care to be given to my child. The decision to give this care will be made by an authorized adult supervisor.

SIGNATURE _____ DATE _____

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 _____

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 FILL OUT THE FRONT SIDE OF THIS FORM ----