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.):
_____

_____

PLEASE FILL OUT BOTH SIDES

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

1. Name _____ Relationship _____ Telephone Number_____

2. Name _____ Relationship _____ Telephone Number _____

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
OR FOR OUT OF STATE TRIPS

Subscribed and sworn to before me on this ____ of _____, 20__.
_____ (Signature) Notary Public for _____ County, Michigan. My commission expires on _____.

DIOCESE OF LANSING
THIS FORM IS EFFECTIVE
July 1, 2015 - JUNE 30, 2016